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Source Book of Health Insurance Data 1984•1985

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Foreword

The 1984-85 edition of the *Source Book of Health Insurance Data* is a statistical report of the private health insurance business in the United States. It is currently published biennially (with selective updates in the interim years) by the Public Relations Division of the Health Insurance Association of America on behalf of companies that provide health insurance to the American public.

This edition of the *Source Book* provides the latest available data on major forms of health insurance: hospital, surgical, physician's expense, major medical, disability and dental insurance. Also included is information on medical care costs, morbidity and health manpower in the United States. The data have been compiled from reports of insurance companies and other health insurance plans, government agencies and hospital and medical associations.

The *Source Book* is used as a reference by writers, editors, researchers, educators, government leaders, hospital and medical professionals, business associations and unions, and others interested in health care and its financing.

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Key Health Insurance Statistics

	1978	1982	1983	% Change 1982-83	% Change 1978-83
Number of Persons with Private Health Insurance Protection in the United States (000 omitted)					
Hospital expense	186,230	191,069	192,216	0.6	3.2
Surgical expense	174,724	180,298	179,057	−0.7	2.5
Physician's expense	166,840	171,642	173,100	0.8	3.8
Major medical expense	142,686	163,089	N.A.	—	—
Disability income:					
Short-term	68,307	68,638	64,146	1.1	−6.1
Long-term	19,100	25,313	24,655	5.7	29.1
Dental expense	55,713	95,265	108,626	8.6	95.0
Health Insurance Benefit Payments in the United States (000,000 omitted)					
Insurance companies	$26,352	$49,159	$53,581	9.0	103.3
Blue Cross-Blue Shield and other plans	25,928	50,354*	57,243*	13.7	120.8
Total†	$48,173	$88,210	$96,559	9.5	100.4
Health Insurance Premiums in the United States** (000,000 omitted)					
Insurance companies	$32,713	$58,341	$ 66,165	13.4	102.3
Blue Cross-Blue Shield and other plans	30,303	52,845*	60,885*	15.2	100.9
Total†	$58,495	$99,488	$112,380	12.9	92.1
Community Hospital Statistics in the United States					
Average length of hospital stay (days)	7.6	7.6	7.6	—	—
Average cost to hospital per patient day	$ 221.90	$ 327.40	$ 369.49	12.9	66.5
Average cost to hospital per patient stay	$1,686.40	$2,488.20	$2,789.18	12.1	65.4

*Estimate.

N.A.—Not available.

**Data for "Insurance companies" refer to earned premiums. Data for "Blue Cross-Blue Shield and other plans" refer to earned income.

†"Total" Benefits and Premiums eliminate the estimated duplication that results from insurance companies and the Health Care Financing Administration ("Other Plans" data) both reporting Administrative Services Only benefits and premiums in their data.

NOTE: Some data are revised from previous editions.

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association, American Hospital Association and U.S. Department of Health and Human Services.

Chapter 1
Extent of Private Health Insurance Coverage

At the end of 1983, more than 192 million Americans -- 82% of the civilian noninstitutional population — were protected by one or more forms of private health insurance (Table 1.1).

These included over 176 million persons under 65 — representing 86% of this age group. Nearly 16 million older persons — 3 in 5 in the 65-and-older population — held private health insurance policies to supplement benefits available through Medicare.

Various forms of private health insurance coverage are available from several different types of insurers: insurance companies, hospital and medical service plans like Blue Cross and Blue Shield, group medical plans operating on a prepayment basis such as health maintenance organizations, and others.

More than 800 private insurance companies in the United States were writing individual and/or group health insurance covering nearly 111 million persons at year-end 1983. Policies issued by insurance companies provide for payment directly to the insured or, if assigned by the insured, to the provider of services for reimbursement of expenses incurred. Health insurance coverage made available by insurance companies can be divided into two basic categories — *medical expense* insurance and *disability income* insurance. *Medical expense* insurance is a "reimbursement type" of coverage which provides broad benefits that can cover virtually all expenses connected with hospital and medical care and related services. *Disability income* insurance provides periodic payments when the insured is unable to work as a result of sickness or injury.

The Blue Cross and Blue Shield Association coordinates the Blue Cross and Blue Shield plans of the nation. The nonprofit member plans service statewide and other geographical areas, offering both individual and group coverage.

Blue Cross plans provide hospital care benefits on essentially a "service type" basis, under which the organization, through a separate contract with member hospitals, reimburses the hospital for covered services provided to the insured.

Blue Shield plans provide benefits for surgical and medical services performed by a physician. The typical Blue Shield plan provides benefits similar to those provided under the benefit provisions of hospital-surgical policies issued by insurance companies. In 1984, there were 67 Blue Cross plans and 67 Blue Shield plans in the United States. 67 of these were joint plans, making a total of 90 Blue Cross and Blue Shield plans.

Health care coverage is also provided through health maintenance organizations (HMOs), which provide comprehensive health care services for their members for a fixed periodic payment. In such plans a group of physicians, surgeons, dentists or optome-

trists furnish needed care as specified in the contract to subscribers. From mid-1971 to January 1985, the number of operational HMOs increased from 33 to 377 and the number of subscribers increased from 3.6 million to 16.7 million.

Certain types of health insurance coverage are also made available by plans that are administered by employers or labor unions, fraternal societies, communities, or by rural and consumer health cooperatives. Usually the protection provided by these groups is the amount desired and affordable by a specific group of people.

It is estimated that some 39% of the total 1983 insurance company group coverage is represented by Administrative Service Only (ASO) arrangements and Minimum Premium Plans (MPPs). Under these systems, corporations and other organizations establish self-funded health plans. Insurance carriers or private organizations are paid a fee by the self-funding group to process the claims and benefits paperwork. Under MPPs, many employers also insure against a certain level of large, unpredictable claims. These two types of arrangements represented approximately 5% of total insurance company group coverage prior to 1975.

Hospital Expense Insurance

At the end of 1983, 192 million persons were covered for hospital expenses by private health insurance (Table 1.2), the most common type of medical expense coverage. This coverage has grown 14% since 1973.

Hospital expense coverage provides specific benefits for daily hospital room and board and usual hospital services and supplies during hospital confinement. Room and board benefits are usually stated in one of two ways: one is reimbursement for the actual room and board charge up to a specified maximum amount per day for hospital confinement. The second provides a service-type benefit that equals the semiprivate room and board charge of the hospital.

Hospital expense benefits are provided in one of three ways: by a hospital expense insurance policy that is often sold in combination with a surgical expense insurance policy so as to also provide benefits for both surgical operations and doctors' in-hospital visits; by major medical policies that provide broad and substantial coverage for many types of medical expenses; and by hospital indemnity policies.

Hospital indemnity coverage is issued to individuals and provides a stipulated daily, weekly or monthly indemnity during hospital confinement. The money is payable without regard to the actual expense of hospital confinement or the existence of other insurance coverage.

A study by the Health Insurance Association of America examined the extent of health insurance coverage among 21.8 million employees covered under group policies at year-end 1980. The results, published in *A Profile of Group Medical Expense Insurance*, show that among the employees with hospital expense coverage, 99% had hospital coverage at a level of 80% or more of the average semiprivate room and board rate in the employee's local area.

At year-end 1983, 15.8 million persons over age 65 were covered by private health insurance, including 7.6

million protected by hospital coverage issued through insurance companies.

Surgical Expense Insurance

At the end of 1983, 179 million persons had protection against the costs of surgery (Table 1.3), a 10% growth since 1973.

This coverage provides benefits for the cost of surgical procedures performed as a result of an accident or sickness. Payment toward charges for administration of an anesthetic for a covered surgical procedure is often included. Benefits under this form of insurance might be paid according to a schedule of surgical procedures, with the policy listing the maximum benefit for each type of operation covered. An increasing number of insurance plans offer surgical benefits for the physician's fee up to the "reasonable and customary" charge for the procedure performed. No separate surgical schedules are included in this type of policy.

The 1980 HIAA *Profile of Group Medical Expense Insurance* showed that 99% of employees were covered under policies that provided surgical expense benefits at a level of 80% or more of the prevailing reasonable and customary charge.

Physician's Expense Insurance

At year-end 1983, 173 million persons (Table 1.4) had physician's expense coverage (formerly termed regular medical expense insurance). This form of health insurance provides benefits to help pay a physician's fees for nonsurgical care in a hospital, home or doctor's office. There are usually maximum benefits for specific services that sometimes include diagnostic X-ray and laboratory expenses.

Major Medical Expense Insurance

Major medical expense insurance — introduced nationally by insurance companies in 1951 — has grown rapidly. By the end of 1983, some 162 million persons under 65 years of age had major medical coverage through insurance company policies, Blue Cross-Blue Shield, HMOs and other independent plans (Table 1.5). Insurance companies alone covered 111 million persons under 65 (Table 1.6).

Major medical coverage provides broad and substantial protection for large, unpredictable medical expenses. It covers a wide range of medical charges with few internal limits and a high overall maximum benefit. Basically, there are two types of major medical plans: one supplements basic hospital-surgical-physician's expense insurance programs; the other provides comprehensive protection where both basic coverage and extended health care benefits are integrated.

Maximum benefits range from $10,000 per person to, in some cases, unlimited benefits. Nearly 90% of the 21.8 million employees in the 1980 HIAA *Profile* study were covered under a major medical expense policy. Some 73% of these had a maximum benefit of $250,000 or more; 46% had a maximum benefit of $1 million or an unlimited amount; and 89% had a maximum of $50,000 or more. In 1970, only 15% of employees with major medical expense coverage had a maximum benefit of $50,000 or more. Two-thirds of the employees had an annual out-of-pocket limit of $1,000 or less. The most common deductible was $100.

A survey of new group major medi-

cal benefits revealed that of those plans issued by insurance companies in 1984, 93% of surveyed employees had maximum benefits of $1 million or more. Some 62% had maximums of $1 million and over, and 31% had unlimited benefits.

Generally, insurance company and medical plan benefits are subject to some form of deductible and coinsurance payments by the insured.

Disability Income Protection

Disability income benefits provide for the partial replacement of income lost by employees as the result of an accident, illness or pregnancy. Generally, disability income policies are divided into two types—those that provide benefits for up to two years (short-term) and those that provide benefits for a longer period, usually for at least 5 years but often to age 65 or for life (long-term).

The amount of the benefit may vary depending upon whether disability is total or partial, and the duration of benefits may vary depending on whether the disability is the result of an accident or an illness. Some policies include a provision whereby monthly income benefits are increased each year according to a predetermined formula which may be related to the cost of living.

When provided on a group basis, the benefits are usually integrated with benefits from Social Security and other public programs. The total level of benefits from these sources is generally set at a level that does not exceed 60% of salary.

Individual disability income policies usually provide a fixed dollar amount of coverage. This amount may be greater for those who are turned down by Social Security. Individual disability income policies take many forms, designed to fit the special needs of the individual policyowner.

Such policies include Return of Premium, Key Person, Overhead Expense, and Buy-Sell Policies. Other types of coverage that may include disability income benefits are travel accident, automobile (including no-fault), accidental death and dismemberment and hospital indemnity insurance.

At the end of 1983, 87 million persons had some form of disability income coverage. This amounts to 86% of employed civilians. Some 64 million persons in the United States were covered by short-term protection through insurance company plans or other formal arrangements, and almost 25 million persons were covered by long-term policies of insurance companies. More than 2 million persons covered by long-term plans also had short-term coverage.

Dental Expense Insurance

Dental expense insurance provides reimbursement for expenses of dental services and supplies and encourages preventive care. The coverage normally provides for oral examinations (including X-rays and cleanings), fillings, extractions, inlays, bridgework and dentures, as well as oral surgery, root canal therapy and orthodontics.

Dental coverage is generally available through insurance company group plans, prepayment plans and dental service corporations.

It is estimated that 109 million persons were protected by some form of

dental expense insurance at year-end 1983 (Table 1.8). This included nearly 32 million persons with coverage under more than one policy or by more than one insuring organization.

The largest providers of this type of protection are insurance companies, which insured 77 million persons through group policies at the end of 1983, compared to 32 million in 1977.

Blue Cross-Blue Shield plans, which first offered dental coverage in the late 1960s, covered 10 million persons at the end of 1983. An additional 53 million persons were covered by dental service corporations, HMOs or through union self-insurance trusts in which union welfare funds directly reimburse dentists in group practice clinics.

The 1980 HIAA *Profile* study found that 46% of employees in the survey had coverage for dental care expenses. Of these, 60% were covered for orthodontia expenses.

The Uninsured and Underinsured Population

Estimates of the number of persons in the United States without private or public protection against health care expenses have been developed by private and governmental agencies.

The purpose of this section is to summarize various studies. No attempt has been made to analyze the accuracy of the findings due to differences in definitions, methodology and time periods covered.

The U.S. Bureau of Census[1] in a fourth quarter report in 1983 estimated that 85% of the population was covered by either government or private health insurance during this period. The population covered by private health insurance was 75 percent, and 61 percent of the total population was covered by a health plan that was related to the current employment of a family member.

In a special report[2] in 1983, the Robert Wood Johnson Foundation revealed that more than 8 percent of the adults — 18.6 million people — reported themselves as uninsured. A total of 23 percent of those who reported having no private or public insurance (including Medicare and Medicaid) also claimed not to have a regular physician or other source of health care.

The most recent report on the uninsured population by the National Center for Health Services Research[3] concludes that there are approximately 27 million uninsured persons of all ages in the United States.

A study conducted for the Urban Institute[4] of Washington, D.C., in 1983 revealed that 32.7 million people were uninsured in 1982. This number represented 16% of the population under age 65.

1. U.S. Department of Commerce, Bureau of the Census. Current Population Reports, Household Economic Studies P70-83-4. *Economic Characteristics of Households in the United States: Fourth Quarter 1983.*
2. The Robert Wood Johnson Foundation. Special Report Number One. 1983. *An Analysis of the Unemployed and the Uninsured.*
3. National Center for Health Services Research. National Health Care Expenditure Study Data Preview No. 1. *Who are the Uninsured?* 1981.
4. The Urban Institute. *The Changing Face of the Uninsured.* June 1984.

Table 1.1
Number of Persons with Health Insurance Protection by Type of Coverage in the United States (000 omitted)

End of year	Hospital expense	Surgical expense	Physician's expense	Major medical expense	Disability income		Dental expense
					Short-term	Long-term	
1940	11,962	4,900	3,000	–	N.A.	N.A.	–
1945	32,072	12,602	4,713	–	N.A.	N.A.	–
1950	76,639	54,156	21,589	–	37,793	*	–
1955	101,400	85,681	53,038	N.A.	39,513	*	–
1960	122,500	111,525	83,172	32,590	42,436	*	N.A.
1961	125,825	116,376	90,393	41,974	43,055	*	N.A.
1962	129,407	119,766	94,717	48,393	45,002	*	N.A.
1963	133,472	124,105	100,095	55,382	44,246	3,029	N.A.
1964	136,304	127,092	106,007	62,112	45,092	3,363	N.A.
1965	138,671	130,530	109,560	69,666	46,927	4,514	N.A.
1966	142,369	133,995	113,986	73,843	49,931	5,068	N.A.
1967	146,409	138,898	119,913	81,550	51,975	6,778	4,570
1968	151,947	143,625	126,233	87,641	55,636	7,836	5,867
1969	155,025	147,774	131,792	95,528	57,770	9,282	8,858
1970	158,847	151,440	138,658	103,544	58,089	10,966	11,972
1971	161,849	153,093	139,399	108,813	59,280	12,284	15,263
1972	164,098	154,687	140,873	113,837	61,548	14,538	16,853
1973	168,455	162,644	151,680	124,627	64,168	17,011	20,418
1974	173,140	166,434	158,170	131,438	65,282	17,799	27,855
1975	178,180	169,002	168,334	134,092	62,971	18,396	30,337
1976	176,858	167,701	163,342	138,657	62,250	17,779	41,703
1977	179,853	168,002	161,289	139,884	64,627	19,364	50,737
1978	186,230	174,724	166,840	142,686	68,307	19,100	55,713
1979	186,808	177,146	167,163	149,914	65,808	19,920	62,174
1980	189,000	178,223	169,529	155,288	68,741	22,051	80,528
1981	188,340	176,898	164,084	156,000	65,301	22,582	84,779†
1982	191,069	180,298	171,642	163,089	68,638	25,313	95,265
1983							
Under 65	176,427	167,694	162,012	161,532	N.A.	24,655	108,626†
65 and over	15,789	11,363	11,088	N.A.	N.A.	–	–
Total	192,216	179,057	173,100	N.A.	64,146	24,655	108,626†

N.A.—Not available.

*Included in "Short-term," with the possibility of some duplication of disability income coverage for these years.

†Estimate.

NOTE: Some data are revised from previous editions. For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions. The data refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association and the U.S. Department of Health and Human Services.

Table 1.2
Number of Persons with Hospital Insurance Protection by Type of Insurer in the United States (000 omitted)

End of year	All insurers*	Insurance Companies			Blue Cross/ Blue Shield	Other plans**
		All insurance companies*	Group policies	Individual and family policies		
1940	11,962	3,700	2,500	1,200	6,012	2,250
1945	32,072	10,504	7,804	2,700	18,899	2,670
1950	76,639	36,955	22,305	17,296	38,822	4,445
1955	101,400	53,480	38,620	19,887	50,726	6,545
1960	122,500	69,226	54,416	22,181	58,050	5,994
1961	125,825	70,367	56,077	22,420	58,664	7,102
1962	129,407	72,156	58,057	23,035	60,118	6,937
1963	133,472	74,478	61,448	23,516	61,016	7,165
1964	136,304	75,825	63,011	23,951	62,054	6,840
1965	138,671	77,642	65,415	24,424	63,347	6,984
1966	142,369	80,419	67,799	24,888	65,310	6,633
1967	146,409	82,603	71,454	24,619	67,214	7,050
1968	151,947	85,705	74,073	25,278	70,019	7,277
1969	155,025	88,798	77,973	25,922	72,692	7,702
1970	158,847	89,688	80,505	26,658	75,055	8,131
1971	161,849	91,531	80,641	27,773	76,539	8,545
1972	164,098	93,681	81,526	29,011	78,206	8,053
1973	168,455	94,544	83,626	27,544	81,345	9,562
1974	173,140	97,010	85,385	28,807	83,845	11,072
1975	178,180	99,547	87,185	30,115	86,436	13,145
1976	176,858	97,038	86,824	26,996	86,601	14,868
1977	179,853	100,378	89,219	28,687	86,024	18,106
1978	186,230	106,480	93,164	36,226	85,816	21,489†
1979	186,808	105,263	95,194	34,612	86,148	25,502†
1980	189,000	107,313	99,108	34,097	86,721	33,152†
1981	188,340	108,372	105,399	25,592	85,773†	40,305†
1982	191,069	112,728	107,027	29,862	82,039†	48,246†
1983						
Under 65	176,427	103,288	105,014	17,865	70,800†	51,400†
65 and over	15,789	7,551	3,286	6,609	8,800†	6,300†
Total	192,216	110,839	108,300	24,474	79,600†	57,700†

*The data in these columns refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

**Other plans include self-insured plans, self-administered plans, plans employing third party administrators, and Health Maintenance Organizations.

†Estimate.

NOTE: Some data are revised from previous editions. For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions. Persons covered under insurance company Administrative Service Only agreements and Minimum Premium Plans are included in the categories "All insurance companies" and "Group policies."

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association and the U.S. Department of Health and Human Services.

Table 1.3
Number of Persons with Surgical Expense Protection by Type of Insurer in the United States (000 omitted)

End of year	All insurers*	Insurance Companies				
		All insurance companies*	Group policies	Individual and family policies	Blue Cross/ Blue Shield	Other plans**
1940	4,900	2,280	1,430	850	370	2,250
1945	12,602	7,337	5,537	1,800	2,845	2,420
1950	54,156	33,428	21,219	13,718	19,690	3,760
1955	85,681	50,146	39,703	14,972	39,165	5,930
1960	111,525	65,093	55,464	16,025	50,281	7,336
1961	116,376	67,103	57,017	16,533	50,166	8,494
1962	119,766	68,814	59,025	16,706	51,342	8,287
1963	124,105	71,580	61,937	17,113	51,845	8,608
1964	127,092	72,802	63,310	17,259	52,953	8,297
1965	130,530	75,186	65,487	17,735	53,945	8,684
1966	133,995	77,434	68,114	17,751	55,968	8,325
1967	138,898	80,090	72,038	17,603	58,248	8,580
1968	143,625	82,088	75,038	17,471	61,336	8,752
1969	147,774	84,850	78,864	17,699	63,926	9,950
1970	151,440	85,661	81,549	17,961	66,042	10,532
1971	153,093	86,254	81,802	18,134	67,203	10,860
1972	154,687	87,395	82,670	18,560	69,072	10,273
1973	162,644	89,061	84,483	18,608	75,136	11,994
1974	166,434	90,879	86,561	18,534	76,873	13,714
1975	169,002	92,089	87,958	18,468	77,803	15,762
1976	167,701	90,744	88,327	16,072	76,943	17,974
1977	168,002	92,799	91,904	14,409	74,523	21,256
1978	174,729	97,112	95,585	16,917	74,604	25,000†
1979	177,146	99,614	97,623	17,930	74,522	29,106†
1980	178,223	100,999	100,559	17,558	73,626	36,885†
1981	176,898	102,024	105,481	12,425	71,771†	44,843†
1982	180,298	105,610	107,987	14,454	68,646†	52,659†
1983						
Under 65	167,694	99,281	103,667	10,797	58,200†	56,900†
65 and over	11,363	3,050	1,249	2,768	7,900†	4,900†
Total	179,057	102,331	104,916	13,565	66,100†	61,800†

*The data in these columns refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

**Other plans include self-insured plans, self-administered plans, plans employing third party administrators, and Health Maintenance Organizations.

†Estimate.

NOTE: Some data are revised from previous editions. For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions. Persons covered under insurance company Administrative Service Only agreements and Minimum Premium Plans are included in the categories "All insurance companies" and "Group policies."

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association and the U.S. Department of Health and Human Services.

Table 1.4
Number of Persons with Physician's Expense Protection by Type of Insurer in the United States (000 omitted)

End of year	All insurers*	Insurance Companies			Blue Cross/ Blue Shield	Other plans**
		All insurance companies*	Group policies	Individual and family policies		
1940	3,000	–	–	–	200	2,800
1945	4,713	535	335	200	1,300	2,878
1950	21,589	8,001	5,587	2,714	11,428	2,873
1955	53,038	22,837	20,537	4,230	29,451	4,639
1960	83,172	37,442	35,522	5,487	45,017	6,773
1961	90,393	40,686	38,154	6,486	45,947	8,583
1962	94,717	43,457	40,557	7,203	47,456	8,343
1963	100,095	47,510	44,541	7,832	48,414	8,647
1964	106,007	52,048	49,447	8,141	49,559	8,850
1965	109,560	55,453	53,258	8,258	50,586	8,718
1966	113,986	59,004	56,851	8,549	52,238	8,434
1967	119,913	62,606	61,028	8,541	54,673	8,680
1968	126,233	66,235	64,566	8,984	57,520	8,900
1969	131,792	69,960	68,872	9,384	59,118	N.A.
1970	138,658	74,888	74,899	10,283	62,273	N.A.
1971	139,399	74,674	75,135	9,936	63,030	N.A.
1972	140,873	75,818	75,920	10,700	64,776	9,462
1973	151,680	79,774	79,862	11,285	71,766	11,222
1974	158,170	82,986	83,642	11,013	74,847	12,982
1975	168,334	86,567	87,027	11,775	74,869	15,289
1976	163,342	87,967	88,886	11,384	74,675	17,255
1977	161,289	88,818	90,159	10,964	71,261	20,880
1978	166,340	91,846	91,684	14,217	70,517	24,529†
1979	167,163	93,158	91,868	15,966	70,439	28,233†
1980	169,529	95,728	95,802	15,962	69,896	32,634†
1981	164,084	94,207	97,309	11,188	68,136†	43,322†
1982	171,642	102,562	104,994	13,864	65,170†	50,865†
1983						
Under 65	162,012	96,162	100,557	10,257	55,300†	55,100†
65 and over	11,088	3,050	1,249	2,768	7,500†	4,800†
Total	173,100	99,212	101,806	13,025	62,800†	59,900†

N.A.—Not available.

*The data in these columns refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

**Other plans include self-insured plans, self-administered plans, plans employing third party administrators, and Health Maintenance Organizations.

†Estimate.

NOTE: Some data are revised from previous editions. For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions. Persons covered under insurance company Administrative Service Only agreements and Minimum Premium Plans are included in the categories "All insurance companies" and "Group policies."

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association and the U.S. Department of Health and Human Services.

Table 1.5
Number of Persons with Major Medical Expense Protection by Type of Insurer in the United States (000 omitted)

End of year	All insurers*	Insurance Companies			Blue Cross/ Blue Shield	Other plans**
		All insurance companies*	Group policies	Individual and family policies		
1951	N.A.	108	96	12	N.A.	N.A.
1955	N.A.	5,241	4,759	482	N.A.	N.A.
1960	32,590	25,371	26,454	1,607	3,713	N.A.
1961	41,974	32,334	34,339	2,372	5,059	N.A.
1962	48,393	37,130	39,081	2,949	7,501	N.A.
1963	55,382	42,003	44,006	3,459	10,000	N.A.
1964	62,112	47,338	49,166	4,185	12,500	N.A.
1965	69,666	53,020	55,412	4,456	14,600	N.A.
1966	73,843	57,881	60,984	4,516	14,352	N.A.
1967	81,550	63,428	67,394	4,552	16,279	N.A.
1968	87,641	68,171	72,436	4,873	17,807	N.A.
1969	95,528	73,752	78,165	5,377	20,328	N.A.
1970	103,544	77,061	81,962	5,414	24,905	N.A.
1971	108,813	80,252	85,553	5,479	26,780	N.A.
1972	113,837	83,668	87,806	6,630	30,082	N.A.
1973	124,627	87,839	91,915	7,310	37,328	N.A.
1974	131,438	91,044	95,532	7,235	40,862	N.A.
1975	134,092	92,166	96,718	7,315	42,058	N.A.
1976	138,657	93,191	98,355	6,672	41,670	11,156
1977	139,884	96,003	101,925	6,101	39,390	14,005
1978	142,686	102,471	108,872	6,890	39,317	17,201†
1979	149,914	104,493	110,809	7,313	43,341	21,125†
1980	155,288	107,218	115,003	7,470	45,000	27,733†
1981	156,000	107,435	115,858	6,633	46,500	33,717†
1982	163,089	111,905	119,679	8,277	47,000†	42,064†
1983						
Under 65	161,532	110,665	119,380	6,796	44,600†	45,400†
65 and over	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
Total	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.

N.A.—Not available.

*The data in these columns refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

**Other plans include self-insured plans, self-administered plans, plans employing third party administrators, and Health Maintenance Organizations.

†Estimate.

NOTE: Some data are revised from previous editions. For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions. Persons covered under insurance company Administrative Service Only agreements and Minimum Premium Plans are included in the categories "All insurance companies" and "Group policies."

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association and the U.S. Department of Health and Human Services.

Table 1.6
Number of Persons with Major Medical Expense Protection with Insurance Companies by Type of Policy in the United States (000 omitted)

End of year	Insurance company total*	Group policies			Individual and family policies
		Net total*	Supplementary	Comprehensive	
1951	108	96	96	–	12
1955	5,241	4,759	3,928	831	482
1960	25,371	24,429	17,991	8,463	1,607
1961	32,334	30,729	24,488	9,851	2,372
1962	37,130	35,002	28,445	10,636	2,949
1963	42,003	39,446	32,307	11,699	3,459
1964	47,338	44,087	36,925	12,241	4,185
1965	53,020	49,700	42,450	12,962	4,456
1966	57,881	54,732	46,830	14,154	4,516
1967	63,428	60,517	51,824	15,570	4,552
1968	68,171	65,076	55,422	17,014	4,873
1969	73,752	70,272	58,905	19,260	5,377
1970	77,061	73,702	61,718	20,244	5,414
1971	80,252	76,971	63,442	22,111	5,479
1972	83,668	79,025	64,443	23,363	6,630
1973	87,839	82,724	66,225	25,690	7,310
1974	91,044	85,979	67,911	27,621	7,235
1975	92,166	87,046	67,310	29,408	7,315
1976	93,191	88,520	66,753	31,602	6,672
1977	96,003	91,733	68,349	33,576	6,101
1978	102,471	98,073	N.A.	N.A.	6,890
1979	104,493	99,821	N.A.	N.A.	7,313
1980	107,218	102,503	N.A.	N.A.	7,470
1981	107,435	103,261	N.A.	N.A.	6,633
1982	111,905	106,630	N.A.	N.A.	8,277
1983					
Under 65	110,665	106,248	66,255	53,125	6,796
65 and over	N.A.	N.A.	N.A.	N.A.	N.A.
Total	N.A.	N.A.	N.A.	N.A.	N.A.

N.A.—Not available.

*The data in these columns refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated.

NOTE: Some data are revised from previous editions. For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions. Persons covered under insurance company Administrative Service Only agreements and Minimum Premium Plans are included in the categories "All insurance companies" and "Group policies."

SOURCE: Health Insurance Association of America.

Table 1.7
Number of Persons with Disability Income Protection by Type of Program in the United States (000 omitted)

End of year	All programs	Insurance Companies			Formal paid sick leave plans	Other plans*
		All insurance companies	Group policies	Individual policies		
1946	26,229	14,369	7,135	8,684	8,400	3,460
1950	37,793	25,993	15,104	13,067	8,900	2,900
1955	39,513	29,813	19,171	13,642	8,500	1,200
1960	42,436	31,836	20,970	14,298	9,500	1,100
Short-Term Disability Income Protection						
1965	46,927	33,527	22,409	11,937	11,700	1,700
1970	58,089	39,789	27,876	14,901	15,900	2,400
1971	59,280	40,180	28,408	13,866	16,500	2,600
1972	61,548	41,208	29,151	14,527	17,640	2,700
1973	64,168	43,298	29,279	16,890	18,170	2,700
1974	65,282	43,672	29,320	17,291	18,910	2,700
1975	62,971	41,071	28,607	15,024	19,400	2,500
1976	62,250	38,940	27,534	13,742	20,610	2,700
1977	64,627	40,047	28,176	14,302	21,880	2,700†
1978	68,307	43,289	28,676	17,606	22,318	2,700†
1979	65,808	40,208	27,005	15,907	22,900†	2,700†
1980	68,741	42,431	29,718	15,209	23,700†	2,700†
1981	65,301	38,201	29,454	10,539	24,400†	2,700†
1982	68,638	41,138	32,465	10,450	24,800†	2,700†
1983	64,146	36,446	28,576	9,482	25,000†	2,700†
Long-Term Disability Income Protection						
1965	4,514	4,514	1,864	2,650	—	—
1970	10,966	10,966	6,954	4,012	—	—
1971	12,284	12,284	7,951	4,333	—	—
1972	14,538	14,538	9,471	5,067	—	—
1973	17,011	17,011	10,595	6,416	—	—
1974	17,799	17,799	11,116	6,683	—	—
1975	18,396	18,396	11,526	6,870	—	—
1976	17,779	17,779	11,516	6,263	—	—
1977	19,364	19,364	12,481	6,883	—	—
1978	19,100	19,100	12,635	6,465	—	—
1979	19,920	19,920	13,409	6,511	—	—
1980	22,051	22,051	15,651	6,400	—	—
1981	22,582	22,582	16,825	5,757	—	—
1982	25,313	25,313	19,163	6,150	—	—
1983	24,655	24,655	19,148	5,507	—	—

*Other plans include self-insured plans, self-administered plans and plans employing third party administrators.

†Estimate.

NOTE: For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions. Data in the category "Insurance companies" refers to the net total of people protected, i.e., duplication among persons who are covered by both group and individual policies has been eliminated. Any duplication resulting from the combination of numbers covered for short-term and long-term protection has not been eliminated. For 1980 and later, this category includes Administrative Service Only agreements and Minimum Premium Plans. The category "Formal paid sick leave plans" refers to people with formal paid sick leave plans but without insurance company coverage. The category "Other" includes union-administered plans.

SOURCES: Health Insurance Association of America and U.S. Department of Health and Human Services.

Table 1.8
Number of Persons with Dental Expense Protection by Type of Insurer in the United States (000 omitted)

End of year	All insurers*	Insurance companies**	Blue Cross/ Blue Shield	Other plans
1967	4,570	2,330	20	2,220
1968	5,867	3,170	35	2,662
1969	8,858	5,159	141	3,558
1970	11,972	7,383	275	4,314
1971	15,263	8,841	1,100	5,322
1972	16,853	10,200	1,110	5,543
1973	20,418	12,097	1,740	6,581
1974	27,855	16,756	3,790	7,309
1975	30,337	18,936	3,318	8,290
1976	41,703	26,562	4,363	11,105
1977	50,737	32,216	5,283	14,234
1978	55,713	36,647	6,800†	17,827†
1979	62,174	43,429	7,100†	22,327†
1980	80,528	55,961	10,000†	27,225†
1981	84,779	61,086	10,400†	35,531†
1982	95,265	68,883	9,100†	44,845†
1983	108,626	77,341†	10,400†	52,600†

*The data in these columns for 1975-83 refer to the net total of people protected, i.e., duplication among persons protected by more than one kind of insuring organization or more than one insurance policy providing the same type of coverage has been eliminated.

**Insurance company data are group plans.

†Estimate.

NOTE: Some data are revised from previous editions. For 1975 and later, data include the number of persons covered in Puerto Rico and U.S. territories and possessions.

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association and the U.S. Department of Health and Human Services.

Chapter 2
Health Insurance Benefit Payments

A total of $97 billion in health insurance benefits was paid by private insuring organizations in the United States in 1983 (Table 2.1), a 9.5% increase over 1982 and four times the amount paid 10 years earlier. The increase was mainly because of the rising cost of medical care, expansion of benefits and higher utilization.

Medical expense benefits, which include payments under hospital, surgical, physician's expense and major medical insurance, totaled $84.2 billion in 1983, an increase of 11.8% over 1982. Dental expense benefits for 1983 totaled $7.4 billion.

Health insurance benefits are provided by private insurers in two ways: through indemnity payments or through service arrangements.

Benefits by insurance companies are primarily provided through indemnity payments, whereby the insured person is paid a specified sum of money toward his covered expenses. (Payments can also be made directly to the provider of care through an assignment of benefits.)

Blue Cross-Blue Shield and other plans usually make direct payments for covered services to the participating hospital or physician.

According to a report by the Social Security Administration (Table 2.3), American workers suffered a $42.6 billion loss in earnings resulting from short-term, nonoccupational sickness or injury during calendar year 1982, an increase of 3.1% over the previous year. Benefits paid under programs providing protection against such income loss amounted to $16.7 billion, a 6.7% increase over 1982. Insurance company group plans provided $3.3 billion of benefits, 19.7% of the total.

The numbers in this chapter refer to benefits paid in the current year and include amounts paid for claims of prior years. However, they exclude amounts which will be paid the following year for claims submitted in the current year. Since the premium figures in the next chapter are reported on an earned basis for the calendar year, thereby reflecting a true picture of premiums for the year, it is not appropriate to compare benefit and premium figures.

A comparison of the benefit and premium figures for loss of income policies is particularly inappropriate. Additions to claim reserves for persons already disabled are extracted from current year premiums but not reflected in the benefit payments. These claim reserves will be used to make income payments for all future years of disability included in coverage under the contracts.

Table 2.1
Health Insurance Benefit Payments by Type of Insurer and by Type of Coverage in the United States (000,000 omitted)

	Year	Total	Medical expense	Dental expense	Loss of income*
All Insurers††	1950	$ 1,347	N.A.	N.A.	$ 383
	1955	3,142	$ 2,547**	N.A.	595
	1960	5,676	4,837**	N.A.	839
	1965	9,624	8,578**	N.A.	1,046
	1970	17,177	15,127	$ 233	1,817
	1975	32,081	28,494	880	2,707
	1976	37,936	33,453	1,599	2,914
	1977	41,674	36,333	2,232	3,109
	1978	48,173	41,939	2,829	3,405
	1979	56,292	48,000	3,588	4,704
	1980	67,087	56,850	4,895	5,342
	1981	76,343	64,785	6,402	5,156
	1982	88,210	75,347	7,307	5,529
	1983	96,559	84,243	7,423	4,893
Insurance Companies	1950	755	372**	N.A.	383
	1955	1,785	1,190**	N.A.	595
	1960	3,069	2,230**	N.A.	839
	1965	5,160	4,114**	N.A.	1,046
	1970	9,089	7,132	140	1,817
	1975	16,470	13,164	599	2,707
	1976	20,217	16,116	1,187	2,914
	1977	22,113	17,552	1,452	3,109
	1978	26,352	21,176	1,771	3,405
	1979	31,692	24,803	2,185	4,704
	1980	37,002	28,865	2,795	5,342
	1981	41,622	32,992	3,474	5,156
	1982	49,159	39,646	3,984	5,529
	1983	53,581	44,316	4,372	4,893
Blue Cross/ Blue Shield and Other Plans	1950	590	N.A.	N.A.	—
	1955	1,357	1,357**	N.A.	—
	1960	2,607	2,607**	N.A.	—
	1965	4,464	4,464**	N.A.	—
	1970	8,088	7,995	93	—
	1975	16,932	16,362	570†	—
	1976	20,020	19,273	747†	—
	1977	22,804	21,784	1,020†	—
	1978	25,928	24,648	1,280†	—
	1979	29,761	28,161	1,600†	—
	1980	37,086	34,986	2,100†	—
	1981	43,701	40,773†	2,928†	—
	1982	50,354	47,031†	3,323†	—
	1983	57,243†	53,137†	4,106†	—

N.A.—Not available.

*Insurance company coverage only.

**Includes dental expense benefit payments.

†Estimate.

††Benefits for "All Insurers" eliminate the estimated duplication that results from insurance companies and the Health Care Financing Administration ("Other Plans" data) both reporting Administrative Services Only benefits in their data.

NOTE: Some data are revised from previous editions. For 1975 and later, data include benefit payments in Puerto Rico and U.S. territories and possessions. Figures do not add to totals in some cases due to rounding. "Medical expense" includes payments for hospital, surgical, physician's expense and major medical benefits. Insurance company benefit payments for 1975 and later include Administrative Service Only agreements and Minimum Premium Plans. Amounts in prior years contained only a portion of this data.

SOURCES: Health Insurance Association of America, Blue Cross and Blue Shield Association and the U.S. Department of Health and Human Services.

Table 2.2
Health Insurance Benefit Payments of Insurance Companies in the United States (000,000 omitted)

Year	Grand total	Group				Individual and family policies		
		Total	Medical expense	Dental expense	Loss of income	Total	Medical expense	Loss of income
1945	$ 278	$ 139	N.A.	N.A.	N.A.	$ 139	N.A.	N.A.
1950	755	438	N.A.	N.A.	N.A.	317	N.A.	N.A.
1955	1,785	1,252	N.A.	N.A.	N.A.	533	N.A.	N.A.
1960	3,069	2,350	$ 1,809	N.A.	$ 541	719	$ 421	$ 298
1961	3,394	2,616	2,082	N.A.	534	778	457	321
1962	3,763	2,911	2,338	N.A.	573	852	519	333
1963	4,152	3,203	2,614	N.A.	589	948	601	347
1964	4,658	3,585	2,953	N.A.	632	1,073	693	380
1965	5,160	4,000	3,322	N.A.	679	1,160	792	368
1966	5,559	4,357	3,608	N.A.	749	1,203	814	389
1967	6,030	4,790	3,953	$ 42	796	1,239	824	415
1968	6,717	5,362	4,360	54	948	1,355	894	461
1969	7,575	6,202	5,027	79	1,096	1,374	897	476
1970	9,089	7,476	6,043	140	1,293	1,613	1,090	523
1971	9,498	8,018	6,541	175	1,301	1,480	1,006	474
1972	10,622	8,943	7,315	201	1,427	1,679	1,148	531
1973	11,863	9,764	7,924	262	1,578	2,099	1,462	637
1974	13,636	11,439	9,260	332	1,847	2,197	1,517	680
1975	16,470	14,191	11,607	599	1,985	2,279	1,557	722
1976	20,217	17,795	14,425	1,187	2,183	2,422	1,691	731
1977	22,113	19,479	15,683	1,452	2,344	2,634	1,869	765
1978	26,352	22,868	18,696	1,771	2,401	3,484	2,480	1,004
1979	31,692	27,934	22,159	2,185	3,590	3,758	2,644	1,114
1980	37,002	33,002	25,895	2,795	4,312	4,000	2,970	1,030
1981	41,622	37,691	30,057	3,474	4,160	3,931	2,935	996
1982	49,159	44,202	36,074	3,984	4,144	4,957	3,572	1,385
1983	53,581	48,094	39,853	4,372	3,869	5,487	4,463	1,024

N.A.—Not available.

NOTE: For 1975 and later, data include benefit payments in Puerto Rico and U.S. territories and possessions. Insurance company benefit payments for 1975 and later include Administrative Service Only agreements and Minimum Premium Plans. Aggregates in prior years contained only a portion of these data. Figures do not add to totals in some cases due to rounding.

SOURCES: *Health Insurance Review*, *Spectator Health Insurance Index*, and Health Insurance Association of America.

Table 2.3
Income Loss and Benefits* Paid for Short-Term Nonoccupational Sickness (000,000 omitted)

Calendar year	Total income loss	Benefit Payments*					
				Group Benefits			
				Private Industry			Govern-ment employees
		Total**	Individual insurance	Private insurance	Public funds	Sick leave	
1950	$ 4,816	$ 942	$ 153	$ 230	$ 63	$ 180	$ 315
1955	6,565	1,620	250	442	109	273	545
1960	8,591	2,430	393	638	172	400	826
1965	11,333	3,349	483	768	269	566	1,264
1970	16,757	5,888	694	1,476	411	1,066	2,242
1971	17,146	6,137	731	1,489	411	1,130	2,376
1972	19,507	6,874	772	1,614	412	1,364	2,712
1973	21,059	7,461	795	1,736	446	1,469	2,906
1974	21,804	8,232	851	2,025	485	1,634	3,107
1975	23,595	9,002	973	2,011	538	1,779	3,542
1976	26,447	9,819	881	2,268	581	2,052	3,868
1977	28,225	10,559	940	2,344	582	2,359	4,144
1978	32,811	11,751	1,210	2,403	690	2,770	4,579
1979	36,072	13,371	1,322	3,216	691	3,072	4,892
1980	38,529	15,076	1,322	3,903	699	3,593	5,337
1981	41,278	15,638	1,322	3,484	699	4,099	5,640
1982	42,558	16,679	1,655	3,281	987	4,581	6,026

*Insurance benefits are reported on an incurred rather than paid basis. Data are not comparable to that shown in Tables 2.1 and 2.2.

**Beginning with 1973, includes benefits for the sixth month of disability payable under OASDI, not shown separately.

NOTE: Detail may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Social Security Administration, unpublished data.

Chapter 3
Health Insurance Premium Income

In 1983, health insurance premium income of all private insuring organizations was $112.4 billion. Americans spent the equivalent of 4.80% of disposable personal income (personal income less personal taxes) in 1983 for health insurance premiums, compared with 4.57% in 1982 (Table 3.1).

Insurance company premiums reported in Tables 3.1, 3.2 and 3.3 are on an earned basis for the calendar year. (Earned premiums are defined as the calendar-year portion of premiums for which the protection of the policy has been provided.)

Because benefit data in the preceding chapter refer to paid benefits and do not include estimates for reserve and liability items, it is inappropriate to compare those benefit data to premium data in this chapter.

Insurance companies earned $66.2 billion in premiums in 1983.

Group and Individual Premiums

Group health insurance premiums paid to private insuring organizations have been increasing substantially for many years. This growth is attributed to the expansion of hospital, surgical and physician's expense protection for employees; to the extension of health insurance coverage to small groups not previously eligible; and to the need to fund larger benefit levels to meet health care cost increases. In 1983, insurance companies earned $56.5 billion in group premiums—some 85.4% of total insurance premiums—and $9.6 billion in individual and family policy premiums.

Table 3.1
Health Insurance Premiums and Ratio to Disposable Personal Income (000,000 omitted)

Premium Income of Insurance Companies, Subscription Income of Blue Cross/Blue Shield and Other Plans in the United States

Year	Insurance companies	Blue Cross/ Blue Shield and other plans	Total premiums**	Disposable personal income	Ratio
1940	$ 286	$ 32	$ 318	$ 75,328	0.42%
1945	550	154	704	149,118	0.47
1950	1,266	687	1,953	206,590	0.95
1955	2,743	1,523	4,266	274,958	1.55
1960	4,671	2,814	7,485	351,992	2.13
1961	5,029	3,246	8,275	365,750	2.26
1962	5,595	3,601	9,196	386,791	2.38
1963	6,145	3,918	10,063	405,879	2.48
1964	6,769	4,332	11,101	440,587	2.52
1965	7,352	4,777	12,129	475,779	2.55
1966	7,796	4,969	12,765	513,690	2.48
1967	8,295	5,247	13,542	547,911	2.47
1968	9,082	5,966	15,048	593,418	2.54
1969	10,197	7,089	17,286	638,933	2.71
1970	11,546	8,439	19,985	695,288	2.87
1971	12,777	10,058	22,835	751,751	3.04
1972	14,771	11,465	26,236	810,322	3.24
1973	16,104	12,908	29,012	914,495	3.17
1974	17,915	14,533	32,448	998,345	3.25
1975	20,795*	17,611	36,967	1,096,068	3.37
1976	24,502*	21,455	43,468	1,194,359	3.64
1977	28,676*	25,333	50,449	1,314,019	3.84
1978	32,713*	30,303	58,495	1,473,991	3.97
1979	37,941*	33,199	65,330	1,650,155	3.96
1980	43,666*	38,630	74,669	1,824,076	4.09
1981	48,998*	45,494†	84,981	2,047,600	4.15
1982	58,341*	52,845†	99,488	2,176,500	4.57
1983	66,165*	60,885†	112,380	2,340,100	4.80

*Insurance company premiums for 1975 and later include Administrative Service Only agreements and Minimum Premium Plans. Aggregates in prior years contained only a portion of these data.

**"Total Premiums" eliminate the estimated duplication that results from insurance companies and the Health Care Financing Administration ("Other Plans" data) both reporting Administrative Service Only premium equivalencies in their data.

†Estimate.

NOTE: Some data are revised from previous editions. For 1975 and later, data include premiums paid in Puerto Rico and U.S. territories and possessions. Data for "Insurance companies" prior to 1972 refer to written premiums (which, for group policies, include minor adjustments to reflect premiums of the particular year). "Insurance companies" premiums for 1972 and later refer to earned premiums and are revised to exclude premiums for accidental death and dismemberment and other such limited coverages. Data for Blue Cross/Blue Shield and other hospital-medical plans refer to earned income. Data for Blue Cross/Blue Shield for 1974 and later include premium taxes.

SOURCES: U.S. Department of Health and Human Services, *Argus Health Chart*, U.S. Department of Commerce, Health Insurance Association of America, and Blue Cross and Blue Shield Association.

Table 3.2
Health Insurance Premiums of Insurance Companies by Type of Policy and by Type of Protection in the United States (000,000 omitted)

Year	Total Premiums	Group policies			Individual and family policies		
		Total	Loss of income	Hospital-medical	Total	Loss of income	Hospital-medical
1935	$ 175	$ 26	$ 26	*	$ 149	N.A.	N.A.
1940	286	65	48	$ 17	221	N.A.	N.A.
1945	55[illegible]	215	125	90	335	N.A.	N.A.
1950	1,266	629	291	338	637	$ 361	$ 276
1955	2,743	1,573	553	1,020	1,170	554	616
1960	4,671	2,895	777	2,118	1,776	744	1,032
1965	7,352	4,683	1,050	3,633	2,669	847	1,822
1966	7,796	5,054	1,183	3,871	2,742	886	1,856
1967	8,295	5,464	1,270	4,194	2,831	948	1,883
1968	9,082	6,088	1,473	4,615	2,994	1,018	1,976
1969	10,197	6,938	1,724	5,214	3,259	1,131	2,128
1970	11,546	8,149	1,968	6,181	3,397	1,104	2,293
1971	12,777	9,170	2,189	6,981	3,607	1,154	2,453
1972	14,771	10,946	2,332	8,614	3,825	1,097	2,728
1973	16,104	11,807	2,414	9,393	4,297	1,304	2,993
1974	17,915	13,193	2,603	10,590	4,722	1,445	3,277
1975	20,795	15,918	2,828	13,090	4,877	1,807	3 070
1976	24,502	19,366	3,144	16,222	5,136	1,854	3,282
1977	28,676	23,234	3,543	19,691	5,442	1,859	3,583
1978	32,713	26,939	4,539	22,400	5,774	1,990	3,784
1979	37,941	31,724	4,933	26,791	6,217	2,096	4,121
1980	43,666	36,801	5,277	31,524	6,865	1,956	4,909
1981	48,998	42,465	5,240	37,225	6,533	1,834	4,699
1982	58,341	50,031	5,499	44,532	8,310	2,533	5,777
1983	66,165	56,536	5,099	51,437	9,629	1,993	7,636

N.A.—Not available.

*Less than $500,000.

NOTE: For 1975 and later, data include premiums paid in Puerto Rico and U.S. territories and possessions. Insurance company premiums for 1975 and later include Administrative Service Only agreements and Minimum Premium Plans. Aggregates in prior years contain only a portion of these data. Data prior to 1972 refer to written premiums (which, for group policies, include minor adjustments to reflect premiums of the particular year) and include accidental death and dismemberment premiums in the Loss of Income categories. Data for 1972 and later refer to earned premiums and are revised to exclude premiums for accidental death and dismemberment and other such limited coverages. The category "Medical expense" includes premiums for hospital, surgical, physician's, dental and major medical protection.

SOURCE: Health Insurance Association of America.

Chapter 4
Federal, State and Local Government Health Care Programs

Medical and health care services are provided through a variety of public programs by all levels of government. In addition, the federal, state and local government agencies often fund research projects and construct medical facilities with public funds. Of the $355.4 billion in national health care expenditures in 1984 (see Chapter 5), $148.8 billion was spent for health and medical care programs at all levels of government (Table 4.1).

As the number of programs funded by public monies has multiplied and expanded, so, too, has the public share of national health expenditures. In fiscal 1973, governmental expenditures for health care were 38.1% of national health expenditures, compared to 41.9% in 1983. The introduction of Medicare produced the largest single-year increase in 1967, during which governmental expenditures rose from 29.5% to 37.0% of national health expenditures.

Federal Programs

Prior to 1967, federal health expenditures were less than half of total government expenditures for health care. In 1983, federal expenditures for health care were more than double state and local expenditures.

The majority of federal health spending is for health services to six major groups: low-income individuals and others eligible for Medicaid services, those over 65 (Medicare), military personnel and their dependents, veterans, federal civilian employees, and native Americans. In 1983, federal budget outlays for health care facilities and services for these groups were 84% of federal health spending.

Medicaid. Title XIX of the Social Security Act provides for a program of medical assistance for certain low-income individuals and families. The program, known as Medicaid, became federal law in 1965.

Medicaid is basically administered by each state within certain broad federal requirements and guidelines. The program is financed jointly by state and federal funds and is designed to provide medical assistance to those groups or categories of persons who are eligible to receive payment under one of the cash assistance programs (i.e., Aid to Families with Dependent Children and Supplemental Security Income). In addition, states may provide Medicaid to the "medically needy," that is, to persons who fit into one of the categories eligible for public assistance, who have enough income to pay for their basic living expenses but not enough to pay for their medical care. As of January 1983, thirty-one states, plus Guam, Puerto Rico, the Virgin Islands and the Nothern Mariana Islands, granted Medicaid eligibility to their "medically needy" populations.

Many members of the Medicaid population are aged or disabled and are also covered by Medicare. In cases where this dual coverage exists, most state Medicaid programs pay for the

Medicare premiums, deductibles and copayments, and for services not covered by Medicare.

In order to qualify for federal matching funds, state programs must include: inpatient hospital services; outpatient hospital services; laboratory and X-ray services; skilled nursing and home health services for individuals aged 21 and older; family planning services; early and periodic screening, diagnosis and treatment for children under 21; and physicians' services at home, in the office, hospital, nursing home or elsewhere.

In 1983, the Medicaid program paid $32.4 billion in benefits to 21.5 million recipients. (Table 4.4).

State participation in the Medicaid program is optional. Currently, all states except Arizona participate in the Medicaid program. The District of Columbia, Guam, Puerto Rico, the Virgin Islands and the Northern Mariana Islands also provide Medicaid coverage.

Medicare. Medicare, which became effective July 1, 1966, is a federally administered program that provided hospital and medical insurance protection for 30 million persons in 1983—those aged 65 and older, persons under age 65 who have been receiving cash benefits under the Social Security or Railroad Retirement programs because they are disabled, and certain chronic kidney disease patients under age 65. Medicare consists of two parts: compulsory hospitalization insurance (HI), also called Part A; and voluntary supplementary medical insurance (SMI), Part B, which helps pay for physicians' services and some medical services and supplies not covered under Part A. Part A is financed by contributions from employers and employees; Part B is voluntary and is financed by monthly premiums paid by those who choose to enroll and by the federal government.

As of January 1, 1985, the out-of-pocket deductible for Part A of Medicare rose to $400 (from $356) for the first 60 days' hospitalization and $100 per day (from $65) for the 61st through the 90th day.

Part B provides benefits equal to 80% of allowed medical-surgical charges after the insured has paid a $75 deductible amount toward those charges. An individual's monthly premium is $15.50.

Prior to 1973, aliens and some federal civil service employees and annuitants were not eligible for Part A of Medicare even though they were age 65 or older. In 1973, the law was amended to allow them to enroll in Part A by paying a monthly premium. The premium, $174 a month, is based on the full cost of hospital care for a high-risk group. These individuals have always had the option of enrolling in Part B.

Since the first full year of Medicare in 1967, benefits paid have increased from $4.5 billion to $60.7 billion in 1983, an increase of 1248% (Table 4.4). Part of the increase is because of the eligibility of certain disabled persons beginning in 1973, so that in 1982 over 13% of total benefits paid went to individuals either blind or disabled Benefits paid under Part A totaled $33.3 billion in 1982, of which $29.4 billion went to those aged 65 and older. Part B paid $14.8 billion, of which $12.4 billion went to the elderly.

Insurance companies, Blue Cross-Blue Shield plans and other independent organizations participate as fiscal intermediaries for the government. In 1984, five private health insurance companies served as fiscal intermediaries for Part A of Medicare, in 45 states and the District of Columbia. Eleven companies distributed benefits under Part B as fiscal intermediaries in 23 states.

On October 1, 1983 1,500 hospitals, representing 30% of the nation's acute care beds, came under the Medicare prospective payment system (PPS) for hospitals. These hospitals, as well as the 3,700 additional hospitals that came under the system in September 1984, are subject to legislation that radically restructures the manner in which hospitals are paid for inpatient services provided to Medicare beneficiaries.

All hospitals with an agreement to participate in Medicare are covered under the PPS, except: psychiatric hospitals; rehabilitation hospitals; children's hospitals; long term care hospitals; distinct psychiatric and rehabilitation units; hospitals in the U.S. territories; and a group of hospitals in the states with an approved waiver.

The cornerstone of the PPS and the basis for payment is the diagnosis-related grouping (DRG) system developed by Yale University researchers in the 1970's as a mechanism for utilization review. DRGs are derived from taking all the possible diagnoses identified in the International Classification of Diseases (ICD-9-CM) system, classifying them into 23 major diagnostic categories (MDCs) based on organ systems, and further breaking them into 467 distinct groupings.

Military Personnel and Dependents. All active and retired military personnel and their dependents are eligible for medical treatment at any Department of Defense (DOD) installation medical facility. Additionally, DOD operates the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to provide reimbursement (after payment of a deductible) for covered medical care provided in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel (unless eligible for Part A of Medicare). The program is designed for those unable to use government medical facilities because of distance, overcrowded facilities or the unavailability of appropriate treatment at a military medical center.

Of the $9.5 billion budgeted for medical care by the Department of Defense in fiscal 1985, $1.4 billion is for medical services reimbursed through CHAMPUS.

Federal Civilian Employees. Civilian employees of the federal government may participate in a variety of insurance programs (including HMOs) through the payment of biweekly premiums by the employing agency and the employee. Nearly 3.7 million federal civilian employees and annuitants were enrolled in 1984, and 5.2 million dependents were also insured in that year. Most annuitants who were covered under the Federal Employees Health Benefits Program when they were employed by the Federal government may elect to continue this coverage. Annuitants already retired when the program became effective in 1960

are eligible to participate in the Retired Federal Employees Health Benefits Program, which, among other options, provides for government payment of the premium for Medicare Part B. Of the 73,732 retirees enrolled in this program on June 30, 1981, 48% had chosen the Medicare Part B option. The remainder were covered under private plans.

In addition to federal payment of the employer contributions under these programs, the federal government also incurs administrative expenses and operates in some federal agencies' in-plant health care facilities for federal civilian employees.

Federal expenditures for these federal civilian health programs in fiscal 1981 were nearly $2.6 billion.

Veterans Medical Care. The Veterans Administration (VA) operates 172 medical centers and 226 outpatient clinics for the care of individuals with active service in the armed forces who were discharged from duty other than dishonorably. Priority is given to patients with service-related ailments. Of the $8.6 billion budgeted by the federal government for VA medical activities in 1984, $8.2 billion was for medical care and hospital services.

Inpatient care was provided to approximately 1.4 million veterans in 1984.

Indian Health Services. A total of $802 million in federal funds was appropriated to provide health services to over 910,000 American Indians and Alaskan natives in 1984. The services included hospital care and other medical services; the construction of hospitals, sanitation facilities and housing for health service employees; health manpower training and education; health planning; and research.

Workers' Compensation Medical Care. The federal government in calendar year 1983 paid $300 million of the $6.4 billion in hospital and medical benefits and administrative expenses under Workers' Compensation laws in the various states (Table 4.5). Hospital and medical costs amounted to about one-third of all Workers' Compensation expenditures.

State and Local Programs

The nation's 53 official State Health Agencies (SHAs) that reported for 1982 spent an estimated $4.7 billion in fiscal 1982, including $1.7 billion of federal funds (Table 4.6). These figures do not include Medicaid expenditures or funds expended for public health purposes by other state agencies. Expenditures for activities of Local Health Departments (LHDs) are included only to the extent that they represent the State Health Agency grants to LHDs.

Not all SHAs perform the same services. In some states certain services are performed by other state agencies. For example, expenditures for mental health services may be controlled by a separate mental health agency.

The public health programs of SHAs can be divided into four program areas, apart from general administrative and service functions: personal health, environmental health, health resources and laboratory services.

Around 73% of SHA expenditures in 1981 (the latest year for which data are available) were for personal health

in nine areas: general and supporting personal health, maternal and child health, communicable disease, handicapped children, dental health, chronic disease, mental health and related programs, SHA operated institutions, and other personal health (for instance, home health care and services to special population groups such as migrants).

There were some 3,200 local health departments in 1983. The territories and possessions (except Puerto Rico and American Samoa) three states and the District of Columbia do not have LHDs.

Table 4.1
Federal, State and Local Government Expenditures for Health and Medical Care

Year	Amount (in billions)			Total per capita	Total as percent of all national health care expenditures (public & private)
	Federal	State and local	Total		
1950	$ 1.6	$ 1.8	$ 3.4	$ 22	26.8%
1955	2.0	2.6	4.6	27	26.0
1960	3.0	3.6	6.6	36	24.5
1965	5.5	5.2	10.8	55	25.9
1966	7.4	6.1	13.6	68	29.5
1967	11.9	7.0	19.0	94	37.0
1968	14.1	8.0	22.1	108	38.0
1969	16.1	8.8	24.9	121	37.9
1970	17.7	10.1	27.8	133	37.2
1971	20.3	11.3	31.7	150	38.1
1972	22.9	12.5	35.4	162	37.7
1973	25.2	14.2	39.4	178	38.1
1974	31.0	16.6	47.6	214	40.2
1975	37.1	19.3	56.4	251	42.5
1976	42.6	20.3	62.8	277	41.7
1977	47.4	22.7	70.1	306	41.2
1978	53.8	26.1	79.9	346	42.1
1979	61.0	29.8	90.9	389	42.3
1980	71.1	34.8	105.8	448	42.7
1981	83.5	38.1	121.7	510	42.6
1982	93.3	42.6	135.8	564	42.1
1983	102.7	46.1	148.8	611	41.9

NOTE: Detail may not add to totals due to rounding.

SOURCE: Health Care Financing Administration, *Health Care Financing Review*, Winter 1984.

Table 4.2
Annual Number of Medicaid Recipients and Benefits Paid By Federal and State Governments* (000,000 omitted)

Fiscal year	Total		Age 65 and over		Families with dependent children		All others	
	Annual recip-ients	Annual benefits paid	Annual recip-ients	Annual benefits paid	Annual recip-ients	Annual benefits paid	Annual recip-ients	Annual benefits paid
1968	N.A.	$ 3,451.4	N.A.	$ 1,534.8	N.A.	$ 850.7	N.A.	$ 1,065.9
1969	N.A.	4,273.4	N.A.	1,757.6	N.A.	1,275.3	N.A.	1,240.5
1970	N.A.	4,807.5	N.A.	1,881.8	N.A.	1,495.6	N.A.	1,430.1
1971	N.A.	5,939.2	N.A.	2,226.1	N.A.	2,003.0	N.A.	1,710.1
1972	N.A.	7,374.9	N.A.	2,702.9	N.A.	2,430.8	N.A.	2,241.2
1973	N.A.	8,810.2	N.A.	3,288.9	N.A.	2,830.1	N.A.	
1974	N.A.	10,148.7	N.A.	3,701.9	N.A.	3,282.3	N.A.	3,164.5
1975	N.A.	12,289.2	N.A.	4,618.3	N.A.	3,962.1	N.A.	3,708.8
1976	N.A.	14,208.3	N.A.	5,190.9	N.A.	4,442.4	N.A.	4,575.0
1977	N.A.	16,289.5	N.A.	5,918.5	N.A.	4,921.8	N.A.	5,449.2
1978	N.A.	17,805.3	N.A.	6,727.3	N.A.	5,042.7	N.A.	6,035.3
1979	N.A.	19,995.9	N.A.	7,646.2	N.A.	5,282.5	N.A.	7,067.2
1980	20.2	23,212.5	3.4	8,738.9	13.5	6,312.5	3.3	8,161.1
1981	20.5	27,104.5	3.4	9,925.7	14.1	7,218.6	3.0	9,960.2
1982	20.1	29,280.2	3.2	10,738.5	14.2	7,503.3	2.7	11,038.4
1983	19.9	32,228.2	3.4	11,953.5	14.2	8,229.6	2.3	12,045.1

*Excludes territories and possessions.

NOTE: Excludes premium and per capita amounts and state expenditures not eligible for federal matching funds.

N.A.—Not available.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research, Demonstrations and Statistics.

Table 4.3
Medicare Enrollments and Benefit Payments (000,000 omitted)

Calendar year	Hospital and/or medical insurance		Hospital insurance (Part A)		Supplementary medical insurance (Part B)	
	Number of enrolled persons*	Benefit payments	Number of enrolled persons*	Benefit payments	Number of enrolled persons*	Benefit payments
All Enrollees						
1966 (July-Dec.)	19.1	$ 1,019	19.1	$ 891	17.7	$ 128
1967	19.5	4,549	19.5	3,353	17.9	1,197
1968	19.8	5,697	19.8	4,179	18.8	1,518
1969	20.1	6,603	20.0	4,739	19.2	1,865
1970	20.5	7,099	20.4	5,124	19.6	1,975
1971	20.9	7,868	20.7	5,751	20.0	2,117
1972	21.3	8,643	21.1	6,318	20.4	2,325
1973	23.5	9,583	23.3	7,057	22.5	2,526
1974	24.2	12,418	23.9	9,099	23.2	3,318
1975	25.0	15,588	24.6	11,315	23.9	4,273
1976	25.7	18,420	25.3	13,340	24.6	5,080
1977	26.5	21,774	26.1	15,737	25.4	6,038
1978	27.2	24,934	26.8	17,682	26.1	7,252
1979	27.9	29,331	27.5	20,623	26.8	8,708
1980	28.5	35,700	28.1	25,064	27.4	10,635
1981	29.0	43,455	28.6	30,342	27.9	13,113
1982	29.5	48,134	29.1	33,333	28.4	14,801
1983	30.0	N.A.	29.6	N.A.	29.0	N.A.
Enrollees Age 65 and Over						
1966 (July-Dec.)	19.1	$ 1,019	19.1	$ 891	17.7	$ 128
1967	19.5	4,549	19.5	3,353	17.9	1,197
1968	19.8	5,697	19.8	4,179	18.8	1,518
1969	20.1	6,603	20.0	4,739	19.2	1,865
1970	20.5	7,099	20.4	5,124	19.6	1,975
1971	20.9	7,868	20.7	5,751	20.0	2,117
1972	21.3	8,643	21.1	6,318	20.4	2,325
1973**	21.8	9,225	21.6	6,803	20.9	2,422
1974**	22.3	11,275	22.0	8,295	21.4	2,980
1975**	22.8	13,994	22.5	10,250	21.9	3,744
1976**	23.3	16,328	22.9	11,959	22.4	4,369
1977**	23.8	19,131	23.5	14,012	23.0	5,119
1978**	24.4	21,713	24.0	15,612	23.5	6,101
1979**	24.9	25,431	24.5	18,143	24.1	7,288
1980**	25.5	30,958	25.1	22,077	24.7	8,881
1981**	26.0	37,640	25.6	26,696	25.2	10,944
1982	26.5	41,787	26.1	29,360	25.7	12,427
1983	27.1	N.A.	26.7	N.A.	26.3	N.A.

*As of July 1.

**Benefits estimated by the Health Care Financing Administration.

N.A.—Not available.

NOTE: Detail may not add to totals due to rounding.

SOURCE: Department of Health and Human Services, Bureau of Data Management and Strategy, Health Care Financing Administration.

Table 4.4
Medicare and Medicaid Benefits by State, 1983

State	Medicare		Medicaid*	
	Benefits paid** (000,000)	Number of persons enrolled (000)	Benefits paid*** (000,000)	Unduplicated count of recipients (000)
Alabama	$ 905	516	$ 368.7	311.3
Alaska	35	15	51.2	20.0
Arizona	745	373	—	—
Arkansas	606	360	313.2	190.3
California	7,072	2,793	3,557.2	3,499.9
Colorado	563	289	255.3	147.6
Connecticut	849	420	495.4	215.5
Delaware	138	72	62.1	45.6
District of Columbia	245	78	196.5	117.7
Florida	4,128	1,883	681.3	555.2
Georgia	1,082	626	601.4	441.1
Hawaii	167	93	141.7	100.3
Idaho	173	113	67.3	39.2
Illinois	3,194	1,408	1,347.0	1,051.0
Indiana	1,244	677	596.0	271.7
Iowa	712	429	312.0	189.5
Kansas	646	336	254.5	147.2
Kentucky	744	483	411.0	388.0
Louisiana	857	459	674.7	378.0
Maine	303	165	205.1	122.2
Maryland	1,092	457	446.6	328.0
Massachusetts	1,909	808	1,338.2†	579.1
Michigan	2,599	1,093	1,421.7	1,187.6
Minnesota	924	536	868.1	326.4
Mississippi	558	337	299.4	290.5
Missouri	1,379	726	468.5	341.6
Montana	170	101	86.2	44.8
Nebraska	380	225	146.0	84.0
Nevada	209	88	73.7	27.9
New Hampshire	217	120	93.1	41.7
New Jersey	2,273	992	981.5	611.9
New Mexico	257	142	101.8	84.4
New York	5,440	2,399	6,259.5	2,160.6
North Carolina	1,136	735	567.0	349.1
North Dakota	193	91	83.3	31.9
Ohio	2,745	1,369	1,474.3	910.6
Oklahoma	746	412	388.7	232.5
Oregon	655	356	236.2	153.8
Pennsylvania	4,049	1,768	1,718.8	1,167.2
Rhode Island	278	145	221.7	104.6
South Carolina	552	359	278.8	236.2
South Dakota	166	102	77.8	33.5
Tennessee	1,068	609	508.6	341.2
Texas	3,325	1,540	1,316.7	680.1
Utah	184	130	114.5	66.0
Vermont	122	68	84.3	53.6
Virginia	1,085	604	488.2	306.4
Washington	859	507	427.1	257.6
West Virginia	482	285	140.6	177.4
Wisconsin	1,175	648	901.1	480.1
Wyoming	76	44	24.4	14.2
United States	$60,720	29,406	$32,228.2	19,936.0
Puerto Rico	—	—	119.8	1,547.1
Virgin Islands	—	—	2.6	11.1
Grand Total	$60,720	29,406	$32,350.5	21,494.2

*Medicaid figures are preliminary.

**Medicare data exclude retroactive adjustment made at end of accounting year on basis of reasonable costs of operation.

***Medicaid data for some states includes expenditures not computable for federal funding.

†Excludes data for the blind.

NOTE: Details may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration.

Table 4.5
Hospital and Medical Expenditures Under Workers' Compensation (000,000 omitted)

Year	State and local	Federal	Total
1965	$ 787	$ 12	$ 798
1966	897	13	910
1967	996	15	1,011
1968	1,130	16	1,146
1969	1,244	18	1,262
1970	1,384	23	1,408
1971	1,414	26	1,440
1972	1,545	29	1,574
1973	1,848	34	1,882
1974	2,133	42	2,175
1975	2,371	59	2,430
1976	2,685	70	2,756
1977	3,053	76	3,129
1978	3,384	93	3,476
1979	4,378	117	4,494
1980	4,901	140	5,042
1981	5,551	162	5,713
1982	5,800	200	6,000
1983	6,100	300	6,400

*For 1970 and succeeding years, data include federal "black lung" benefits.

NOTE: Figures have been revised to include total health and medical expenditures of the Workers' Compensation program, rather than only benefits paid. Details may not add to totals due to rounding.

SOURCE: Health Care Financing Administration, *Health Care Financing Review*, September 1982 and Winter 1984.

Table 4.6
Public Health Programs of State Health Agencies: Expenditures and Persons Served, 1982 (000 omitted)

State	Expenditures by source				Personal health services*	
	Total	Federal	State	Other**	Expenditures (included in total)	Persons receiving any service†
Alabama	$ 58,526	$ 34,591	$ 22,696	—	$ 1,238	1,164
Alaska	21,944	3,192	17,619	$ 1,091	42	387
Arizona	107,771	27,610	70,225	3,271	6,666	1,274
Arkansas	42,160	15,856	23,355	—	2,949	472
California	482,578	154,564	328,014	—	N.A.	3,678
Colorado	61,898	31,982	29,916	—	N.A.	402
Connecticut	47,241	24,104	23,136	—	N.A.	650
Delaware	25,869	4,379	20,643	432	116	285
District of Columbia	80,529	22,797	57,732	—	N.A.	553
Florida	165,554	54,068	68,062	2,368	41,056	1,758
Georgia	110,828	51,640	58,179	279	730	1,416
Hawaii	148,308	12,029	87,445	273	48,560	507
Idaho	20,099	12,853	6,744	72	430	315
Illinois	80,381	46,874	36,342	—	164	4,224
Indiana	45,832	26,218	19,615	—	N.A.	592
Iowa	25,371	16,323	9,022	26	N.A.	336
Kansas	29,632	17,193	11,219	—	1,220	1,291
Kentucky	163,475	42,334	88,883	—	32,259	1,323
Louisiana	92,446	41,839	31,306	9,622	9,679	1,507
Maine*	—	—	—	—	—	—
Maryland	390,150	50,284	299,722	5,106	35,039	687
Massachusetts	126,810	23,901	99,440	—	3,469**	2,359
Michigan	188,453	76,020	91,339	1,019	20,074	1,409
Minnesota	56,274	30,981	24,421	856	17	1,700
Mississippi	66,079	35,008	14,383	—	16,688	1,009
Missouri	67,421	31,579	24,734	8	11,100	906
Montana*	—	—	—	—	—	—
Nebraska	16,760	10,961	3,917	69	1,814	259
Nevada	15,523	7,568	6,625	—	1,061	266
New Hampshire	12,063	7,292	4,771	—	N.A.	127
New Jersey	104,530	51,400	48,319	2,396	1,415	963
New Mexico	82,422	13,547	51,680	1,155	15,039	273
New York	397,703	120,800	276,903	—	N.A.	1,610
North Carolina	122,693	52,795	51,648	18,250	N.A.	2,483
North Dakota	13,365	9,601	3,267	340	157	254
Ohio	102,372	63,394	31,266	997	6,715	2,918
Oklahoma	61,986	22,457	26,878	2,638	10,013	925
Oregon	27,548	16,920	5,443	—	5,185	375
Pennsylvania	187,863	74,154	109,673	109	3,977	4,087
Rhode Island	26,969	10,433	16,536	—	N.A.	297
South Carolina	120,321	49,222	53,047	1,930	16,123	727
South Dakota	12,930	8,169	2,971	737	1,053	308
Tennessee	103,636	49,043	42,278	174	12,141	1,407
Texas	211,045	86,256	109,918	12,166	2,706	8,967
Utah	26,304	14,160	10,721	137	1,286	476
Vermont	15,195	10,402	4,634	72	88	191
Virginia	141,644	37,427	58,016	3,897	42,304	1,293
Washington	45,082	26,130	15,993	—	2,959	1,307
West Virginia	111,729	20,982	87,312	1,235	2,199	692
Wisconsin*	—	—	—	—	—	—
Wyoming	11,191	4,310	6,028	—	845	462
U.S. Territories	13,191	2,073	11,118	—	—	—
Grand Total	$4,692,694	$1,657,725	$2,603,104	$70,725	N.A.	60,862

N.A.—Not available.

*The Public Health Agencies in American Samoa, Guam, Maine, Montana, The Northern Mariana Island, and Wisconsin did not report to the ASTHO Foundation for FY 1982.

**Additional fees were collected by the state health agency for services provided. Those additional fees reverted to the general revenues of the state.

†Estimated unduplicated count.

NOTE: The data in this table relate only to expenditures of official state health agencies. The public health expenditures of other agencies such as separate mental health authorities, environmental agencies, and hospital authorities are not reflected in the ASTHO Foundation's data base.

SOURCE: Association of State and Territorial Health Officials, 10400 Connecticut Avenue, Kensington, MD 20895.

Chapter 5
Medical Care Costs

Each year Americans spend more money for medical care. The increases result from a combination of factors — higher costs, greater demand for health services, rising incomes, and growth and availability of private health insurance. Other major influences include the introducion of newer and costlier medical techniques and procedures, higher educational level of the population (which is generally associated with greater expenditures for personal health care), growing awareness of the availability of medical care, and a rising proportion of elderly persons in the population, who, as a group, are prone to a higher incidence of health-related problems.

Total Medical Expenditures

In this chapter, spending for health care is discussed in terms of National Health Expenditures, Personal Health Care Expenditures, Personal Consumption Expenditures for Medical Care, the Consumer Price Index.

National Health Expenditures

Total health care spending, represented by the **National Health Expenditure (NHE)** figure, includes both private and public expenditures for personal health care, medical research and construction of medical facilities, administrative and health insurance costs, and government-sponsored public health activities. Because of its all-inclusive nature, the National Health Expenditure will be discussed in terms of, and compared to, the Gross National Product. The National Health Expenditure figure covers spending for health care over the 12-month calendar year.

National health spending reached $355.4 billion in 1983 (Table 5.1), or an average of $1,460 per person.

Total health expenditures showed a 10.3% increase in 1983, compared with a 12.8% increase in 1982. Public spending, which financed 42.1% of all health care costs in 1982, decreased to 41.9% of the total in 1983, while private spending rose 10.8%..

Hospital care continued to represent the largest share of spending for health care, totaling $147.2 billion in 1983. The cost of physicians' services was the next highest at $69 billion.

In 1965, National Health Expenditures constituted 6.0% of the Gross National Product. This proportion has continued to increase over the years, reaching 10.8% in 1983 before falling slightly to 10.7% in 1984.

According to projections made by the Health Care Financing Administration, National Health Expenditures will reach $465 billion in 1985, and $756 billion by 1990. Per capita expenditures are projected to be $1,882 in 1985, almost 30% more than the 1983 figure of $1,460. By 1990, per capita expenditures are projected to be $2,982.

Personal Health Care Expenditures

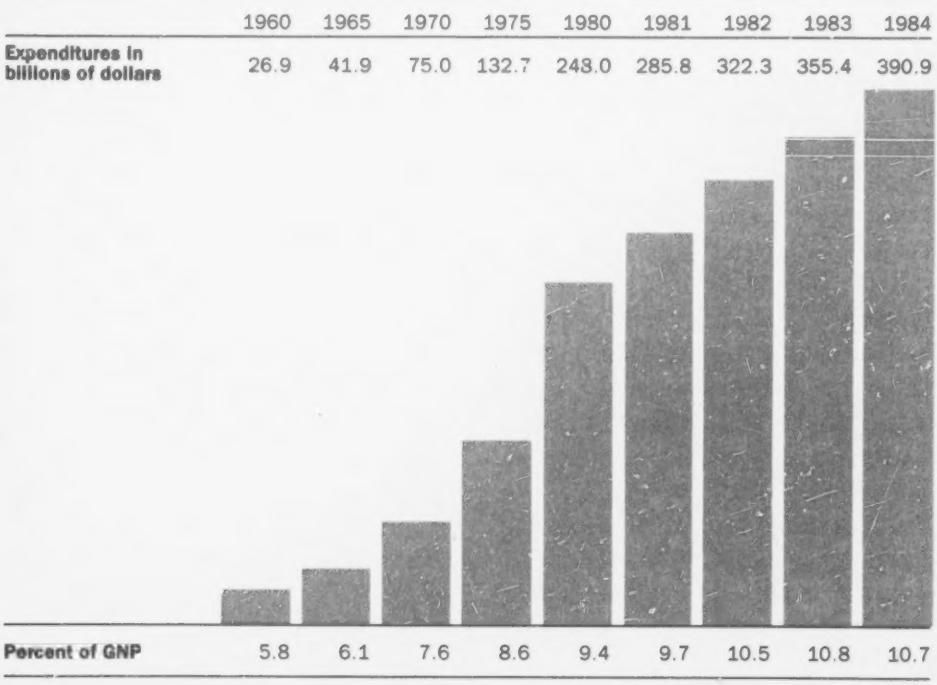
The Personal Health Care Expenditure (PHCE) figure represents private and public spending for health and medical services for the direct benefit of the individual, representing 88% of 1983 National Health Expenditures.

Spending for personal health care in the nation amounted to $313.3 billion in 1983 (Table 5.4). This sum includes all outlays for health and medical services for the direct benefit of the individual, including both public and private spending.

Included are expenditures for hospital care, physicians', dentists' and other professional services, drugs and medical sundries, eyeglasses and appliances, nursing home care, and spending for in-plant health services. Not included are expenditures for medical research, construction of medical facilities, public health activities such as disease prevention and control, and the net cost of health insurance — the difference between premiums and benefits paid. (The latter items are included in the National Health Expenditure figure.)

Table 5.5 shows per capita amount of personal expenditure by age group and type of expenditure for 1981. These provisional estimates by the Health Care Financing Administration indicate each person under the age of 65 spent an average of $392 for hospital care and $189 for physicians' serv-

National Health Expenditures and Percent of Gross National Product



ices. Americans 65 years of age and over spent an average of $1,381 for hospital care, $589 for physicians' services and $732 each for nursing home care.

A projection by the Health Care Financing Administration indicates that there will be little change in the age distribution of expenditures in the next 20 years with persons 20 to 64 years of age accounting for more than 60% of the total in 2003. Persons 20 to 64 years of age would continue to account for 60% of the total expenditures for both hospital care, and physicians' services. The projected growth in spending is greatest for nursing home care. Under the constant mortality assumption, expenditures will increase 56%, while under a declining mortality assumption, the increase will be 109%, indicating that total spending for nursing home care would more than double.

The largest portion of the personal health care dollar is financed by third-party sources (Table 5.8). Private health insurance, philanthropy, industry and the government paid 73% of all expenditures for personal health care in 1983.

Personal health care figures include expenditures of all consumers, whether insured or not. Included are expenses for non-prescribed drugs and medicines, household supplies such as tissues and rubbing alcohol, and other items not covered by insurance.

In terms of the growth of personal health care components, hospital care has been the fastest growing category of expenditures. In 1970, monies spent for hospital care represented 43% of personal health care expenses. By 1983, the proportion rose to 47%.

Personal Consumption Expenditures

Personal Consumption Expenditures (PCE) for medical care represent private payments, although monies from three government programs (Medicare, Workers' Compensation and Temporary Disability Insurance) are treated as transfer payments and are included. The PCE is computed as an annual average.

While the same basic categories of expenditures constitute the PCE for medical care and the PHCE portion of the NHE figure, different accounting practices are used for each. Some important distinctions include:

(1) With respect to hospital costs, the PHCE figure focuses on personal outlays for hospital services and does not include the cost of providing services; the PCE includes the latter item for private, nonprofit hospitals.

(2) The PCE includes the net cost of health insurance (i.e., earned premiums less benefits paid) but the PHCE does not. However, this figure is included in the NHE data.

Personal Consumption Expenditures for medical care were $234.9 billion for calendar year 1983 (Table 5.9), three and one-half times the amount spent 10 years earlier. The 1983 amount represented 10.9% of the total spent by Americans on all personal needs, compared with 8.3% a decade earlier.

As a proportion of the public's disposable personal income, these expenditures were 9.1% in 1983, up from 7.4% in 1973 (Table 5.10).

Personal Consumption Expenditures for nongovernmental hospital care (including expenses of nonprofit hospitals, sanitariums and nursing homes,

Projected Expenditures for Physicians' Services, Hospital Care, and Nursing Home Care, and Percent Distribution by Age: United States, 1978 and 2003

	Physicians' Services			Hospital Care			Nursing Home Care		
	1978	2003 constant mortality	2003 declining mortality	1978	2003 constant mortality	2003 declining mortality	1978	2003 constant mortality	2003 declining mortality
Expenditures in billions of dollars	36.3	47.2	49.6	73.9	97.5	105.8	14.5	22.6	30.3
Percent Distribution									
Under 20 years	15.4	12.7	12.3	9.6	7.8	7.3	—	—	—
20-64 years	62.5	64.2	61.9	62.7	62.4	59.2	—	—	—
Under 65 years	—	—	—	—	—	—	16.6	13.3	9.9
65 years and over	22.3	23.1	25.8	27.7	29.8	33.6	83.4	86.7	90.1

SOURCE: U.S. Department of Health and Human Services, *Changing Mortality Patterns, Health Services Utilization, and Health Care Expenditures: United States 1978-2003.*

and payments by patients to proprietary hospitals, sanitariums and nursing homes) were $104.1 billion in 1983 (Table 5.11), and over four times the amount in 1973. Payments for physicians' services were $61.2 billion, three and one-half times the amount spent a decade earlier.

Consumer Price Index

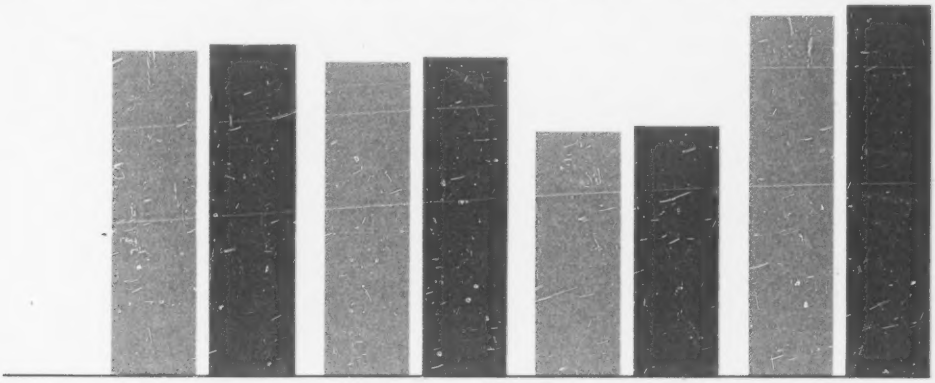
The Consumer Price Index (CPI) measures the average change in prices of all types of consumer goods and services purchased by urban wage earners and clerical workers. The index measures the effect of *price change only* on the cost of living. It does *not* measure changes in the total amount families spend.

According to the Consumer Price Index (CPI), in 1984, medical costs increased by 6.2% over 1983 compared to a 4.3% increase for all items (Table 5.13).

Individual components of medical care have differed in their rate of increase. Hospital room rates have risen most rapidly. The disproportionate rate of increase for hospital charges is due in no small part to the fact that

Average Cost to Patient Per Day for Semiprivate Hospital Room by Region

	Northeast		North Central		South		West	
	July 1984	Jan. 1985	July 1984	Jan. 1985	July 1984	Jan. 1985	July 1984	Jan. 1985
Dollars	222.29	225.08	213.67	216.14	165.61	169.83	245.66	250.03



NOTE: Northeast includes New England and Middle Atlantic states; North Central, East North Central and West North Central states; South, South Atlantic, East South Central and West South Central states; and West, Mountain and Pacific states. Data exclude Puerto Rico.

SOURCE: Health Insurance Association of America, *Survey of Hospital Semiprivate Room Charges*, Jan. 1985.

the CPI index for hospital charges is based on the published charges, i.e., those charges made to patients insured by private insurance companies or to patients without any private or government coverage for hospital care costs. These charges are disproportionately higher than the actual per patient cost. The reason for this is that hospitals must make up revenues lost due to bad debts, charity cases, fixed reimbursement schedules under Medicare and Medicaid, and negotiated reimbursement levels of many community-rated health insurers. The resulting shortfall is shifted to insurance company patients or to those with no insurance coverage. To illustrate, statistics compiled by the Health Insurance Association of America indicate that the average hospital bill for a private nongovernment patient is nearly 13% higher because of this practice.

Hospital Charges

Community Hospital Statistics. The average cost to community hospitals to treat a person in 1983 was $369.49 per patient-day, a 13% increase over 1982. On a state-by-state basis, the average cost per day in 1983 varied considerably from a low of $244.24 in South Dakota to a high of $577.60 in Alaska.

In 1983, the average length of time a patient remained in a community hospital was 7.6 days. For the past seven years the average length of stay has remained 7.6 days, following several years of steady decline.

Although the length of the average hospital stay has remained the same over the seven-year period, the cost for the average stay went up, climbing 139% from 1976 to reach $2,789.18 per patient stay.

The average length of stay varied by

area, from a low of 5.4 days in Utah to a high of 9.6 days in New York. Differences reflect the incidence of various diseases, age distribution of the population, income levels and postponement of non-emergency admissions.

Operating costs of community hospitals increased to $116.4 billion in 1983, 158% more than the $45.2 billion in 1976, and 52% higher than in 1980.

The American Hospital Association reports that payrolls reached $55.5 billion, representing 47.7% of community hospital expenditures in 1983. Prior to 1983, payroll as a proportion of expenditures had been steadily decreasing since 1962, when it was 61.9% of expenditures.

Semiprivate Room Charges. A continuing survey conducted by the Health Insurance Association of America shows that as of January 1985, the national average daily cost to the patient for a semiprivate room was $212.77, a 1.6% increase over July 1984 (Table 5.17). Survey results are based on responses from 2,350 nongovernmental short-term general hospitals nationwide. The highest average rate was in the West, at $250.03 per day. The lowest average rate was in the South, at $169.83 per day.

Professional Fees

Surgical and Dental Charges. Surgical charges vary considerably by geographic region and by metropolitan and nonmetropolitan areas. Table 5.18, containing data from a 1984 survey by the Medical Economics Magazine, shows the variance of some common surgical procedures and emergency medical procedures across the United States.

Results of a 1984 survey of average dental charges by Procom (Table 5.19), show variation by geographic region.

Physician Fees. Tables 5.20 and 5.21 show, physician fees vary considerably by type of practice or speciality, type of visit and region of the United States. In 1984, the median charges for an initial office visit and an office revisit were highest for specialists and for physicians practicing in the Western states.

Cost of Having a Baby

In 1982, the Health Insurance Association of America conducted a national survey to determine the medical costs incurred in having a baby. As shown in Table 5.22, the average cost for an uncomplicated normal delivery in a delivery room varied from $1,615.80 in the rural West to $2,312.50 in the urban Northeast. The difference in cost is more marked between urban and rural areas than among the four regions of the United States. The cost of a cesarean is considerably higher than a normal delivery — the U.S. average for an uncomplicated cesarean is $3,340.30, compared to $2,092.70 for an uncomplicated normal delivery.

Medical Costs Resulting from Accidents

The economic losses that result from various types of accidents are shown in Table 5.23. Medical expense costs incurred through accidents totaled $12.7 billion in 1983.

Table 5.1
National Health Expenditures, 1983 by Type of Expenditure and Source of Funds (000,000 omitted)

Type of Expenditure	Total	Private*	Public
Personal health care	$313.3	$188.8	$124.5
Program administration and net cost of insurance	15.6	10.9	4.6
Government public health activities	11.2	—	11.2
Research	6.2	0.4	5.8
Construction	9.1	6.5	2.6
Total	$355.4	$206.6	$148.8

*Includes spending by philanthropic organizations.

NOTE: Details may not add to total due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, Winter 1984.

Table 5.2
Comparison of Growth Rates of Gross National Product and National Health Expenditures

	Gross National Product		National Health Expenditures		
Calendar year	Amount (000,000,000)	Annual rate of growth	Amount (000,000,000)	Annualized percentage change	NHE as percent of GNP
1950	$ 286.5	11.1%	$ 12.7	12.2%	4.4%
1955	400.0	6.9	17.7	7.0	4.4
1960	506.5	4.8	26.9	8.7	5.3
1965	691.0	6.4	41.7	9.2	6.0
1970	992.7	5.2	74.7	13.6	7.5
1971	1,077.6	8.6	83.3	11.5	7.7
1972	1,185.9	10.1	93.9	12.7	7.9
1973	1,326.4	11.8	103.4	10.1	7.8
1974	1,434.2	8.1	116.3	12.5	8.1
1975	1,549.2	8.0	132.7	14.0	8.6
1976	1,718.0	10.9	150.8	13.6	8.8
1977	1,918.3	11.7	170.2	12.9	8.9
1978	2,163.9	12.8	190.0	11.7	8.8
1979	2,417.8	11.7	215.1	13.2	8.9
1980	2,631.7	8.8	248.0	15.3	9.4
1981	2,957.8	12.4	285.8	15.2	9.7
1982	3,069.2	3.4	322.3	12.8	10.5
1983	3,304.8	7.8	355.4	10.3	10.8
1984	3,662.8	10.8	390.9†	10.0	10.7

†Estimated.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, Winter 1984 and unpublished data.

Table 5.3
Aggregate and Per Capita Amount and Percentage Distribution of National Health Expenditure by Type of Expenditure, Selected Calendar Years, 1965-1985

Type of expenditure	Historical year						
	1965	1970	1975	1980	1982	1983	1985*
Aggregate Amount (In billions)							
Total	$41.9	$75.0	$132.7	$248.0	$322.3	$355.4	$456.4
Health services and supplies	38.4	69.6	124.3	236.1	308.1	340.1	438.4
Personal health care expenses	35.9	65.4	117.1	219.1	284.7	313.3	408.2
Hospital care	14.0	28.0	52.4	101.3	134.9	147.2	196.7
Physicians' services	8.5	14.3	24.9	46.8	61.8	69.0	87.9
Dentists' services	2.8	4.7	8.2	15.4	19.5	21.8	26.8
Other professional services	1.0	1.6	2.6	5.6	7.1	8.0	10.1
Drugs and medical sundries	5.2	8.0	11.9	18.5	21.8	23.7	30.2
Eyeglasses and appliances	1.2	1.9	3.2	5.1	5.5	6.2	7.3
Nursing home care	2.1	4.7	10.1	20.4	26.5	28.8	38.9
Other health services	1.1	2.1	3.8	5.9	7.6	8.5	10.3
Program administration and net cost of insurance	1.7	2.8	4.0	9.2	13.4	15.6	20.8
Government public health activities	.8	1.4	3.2	7.7	10.0	11.2	9.4
Research and medical facilities construction	3.5	5.4	8.4	11.9	14.2	15.3	18.0
Research	1.5	2.0	3.3	5.4	5.9	6.2	6.5
Construction	2.0	3.4	5.1	6.5	8.3	9.1	11.5
Per Capita Amounts							
Total	$211	$351	$604	$1,049	$1,337	$1,460	$1,882
Health services and supplies	193	325	565	999	1,278	1,397	1,808
Personal health care expenses	181	306	531	927	1,181	1,287	1,683
Hospital care	70	131	237	429	560	605	811
Physicians' services	43	69	113	202	256	284	362
Dentists' services	14	23	37	67	81	90	111
Other professional services	5	8	12	24	29	33	42
Drugs and medical sundries	26	38	54	78	90	97	125
Eyeglasses and appliances	6	9	14	22	23	26	30
Nursing home care	10	23	46	86	110	118	160
Other health services	6	10	17	25	32	35	43
Program administration and net cost of insurance	8	13	20	39	57	64	86
Government public health activities	4	7	14	33	42	46	39
Research and medical facilities construction	18	26	38	50	59	63	74
Research	8	9	15	23	25	26	27
Construction	10	16	23	28	34	37	47

NOTE: Details may not add to totals due to rounding.

*Projected

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, Winter 1984.

Table 5.4
National Health Care Expenditures, 1982 and 1983 by Type of Expenditure and Source of Funds
(000,000,000 omitted)

Type of Expenditure	Total	Private			Public	
		Consumer				
		Direct	Insurance	Other*	Federal	State and Local
1983						
Total	$355.4	$85.2	$110.5	$10.9	$102.7	$46.1
Health services and supplies	340.1	85.2	110.5	4.1	96.8	43.5
Personal health care	313.3	85.2	100.0	3.7	93.0	31.5
Hospital care	147.2	11.1	56.2	1.5	60.6	17.8
Physicians' services	69.0	19.6	30.1	—	15.6	3.7
Dentists' services	21.8	13.9	7.4	—	0.3	0.3
Other professional services	8.0	3.3	2.1	0.1	1.9	0.5
Drugs and medical sundries	23.7	18.4	3.2	—	1.1	1.1
Eyeglasses and appliances	6.2	4.5	0.7	--	0.9	0.1
Nursing home care	28.8	14.4	0.3	0.2	8.1	5.9
Other health services	8.5	—	—	1.8	4.5	2.1
Program administration and net cost of insurance	15.6	—	10.5	0.5	2.6	2.0
Government public health activities	11.2	—	—	—	1.2	10.0
Research and medical facilities construction	15.3	—	—	6.8	5.9	2.6
Research	6.2	—	—	0.4	5.2	0.6
Construction	9.1	—	—	6.5	0.7	2.0
1982						
Total	$322.3	$77.2	$ 99.3	$ 9.9	$ 93.3	$42.6
Health services and supplies	308.1	77.2	99.3	3.8	87.6	40.1
Personal health care	284.7	77.2	90.8	3.4	84.0	29.4
Hospital care	134.9	10.3	51.4	1.4	55.3	16.4
Physicians' services	61.8	17.8	27.1	—	13.4	3.5
Dentists' services	19.5	12.4	6.5	—	0.3	0.3
Other professional services	7.1	3.1	2.0	0.1	1.5	0.5
Drugs and medical sundries	21.8	16.9	2.9	—	1.0	1.0
Eyeglasses and appliances	5.5	4.1	0.6	—	0.7	0.1
Nursing home care	26.5	12.7	0.2	0.2	7.7	5.7
Other health services	7.6	—	—	1.7	4.1	1.8
Program administration and net cost of insurance	13.4	—	8.6	0.4	2.4	1.9
Government public health activities	10.0	—	—	—	1.2	8.8
Research and medical facilities construction	14.2	—	—	6.1	5.6	2.5
Research	5.9	—	—	0.3	5.0	0.6
Construction	8.3	—	—	5.8	0.6	1.9

*Spending by philanthropic organizations, industrial in-plant services, and privately financed construction.

NOTE: Details may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, Winter 1984.

Table 5.5
Per Capita Amount of Personal Expenditures by Age & Type of Expenditure, 1981*

Type of expenditure	Per capita amount								
	All ages			Under age 65			Age 65 and over		
	Total	Private	Public	Total	Private	Public	Total	Private	Public
Hospital care	$ 504	$230	$274	$392	$234	$158	$1,381	$ 200	$1,181
Physicians' services	234	170	64	189	160	29	589	249	340
Dentists' services	74	71	3	72	69	3	91	87	4
Other professional services	27	21	6	21	18	3	75	45	30
Drugs & medical sundries	91	83	8	79	74	5	192	158	34
Eyeglasses & appliances	24	21	3	23	22	1	38	23	15
Nursing home care	103	45	58	23	5	18	732	362	370
Other health services	31	7	24	30	7	23	38	4	34
Total	$1,090	$650	$440	$828	$588	$240	$3,140	$1,132	$2,008

*Provisional estimate

SOURCE: U.S. Depart nent of Health & Human Services, *Health Care Financing Administration*, unpublished data.

Table 5.6
Factors Affecting Growth of Personal Health Care Expenditures: Twelve Month Period Ending December

	1979	1980	1981	1982	1983
All factors	100%	100%	100%	100%	100%
Prices	72	72	72	78	70
Population	8	7	6	8	11
Intensity	20	21	22	14	19

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, unpublished data and *Health Care Financing Review*, Winter 1984.

Table 5.7
Personal Health Care Expenditures by Type of Payer and Type of Expenditure, 1983

Source of payment	Total personal care	Hospital care	Physicians' services	Dentists' services	Nursing home care	Other health services
Total	$313.3	$147.2	$69.0	$21.8	$28.8	$46.4
Direct payments	85.2	11.1	19.6	13.9	14.4	26.2
Third party payments	228.1	136.1	49.5	7.9	14.4	20.3
Private Health Insurance	100.0	56.2	30.1	7.4	.3	6.0
Philanthropy and industrial inplant	3.7	1.5	*	—	.2	1.9
Government	124.5	78.4	19.3	.6	14.0	12.2
Federal	93.0	60.6	15.6	.3	8.1	8.4
Medicare	57.4	40.4	13.4	—	.5	3.2
Medicare	18.1	6.9	1.6	.3	7.0	2.4
Other	17.4	13.3	.6	*	.5	2.9
State and local	31.5	17.8	3.7	.3	5.9	3.8
Medicaid	15.8	6.7	1.4	*	5.4	1.7
Other	15.7	11.1	2.3	*	.5	1.7

*Less than $50,000,000.

NOTE: Details may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financin Review*, Winter 1984.

Table 5.8
Personal Health Care Expenditures by Source of Payment in the United States (000,000,000 omitted)

Calendar year	Total	Direct payments	Third Party Payments			
			Total	Private health insurance	Govern-ment	Philan-thropy and industry
1966	$ 39.7	$19.6	$ 20.0	$ 9.1	$ 10.1	$0.8
1967	44.5	19.0	25.5	9.6	15.1	0.8
1968	50.3	20.7	29.6	10.9	17.8	0.9
1969	57.1	23.0	34.0	12.9	20.2	0.9
1970	65.4	26.5	38.9	15.3	22.4	1.1
1971	72.2	28.1	44.1	17.2	25.6	1.3
1972	80.5	30.6	49.9	19.0	28.8	2.0
1973	89.0	33.3	55.7	21.4	32.1	2.2
1974	101.5	35.8	65.6	25.1	39.0	1.5
1975	117.1	38.0	79.1	31.2	46.3	1.6
1976	132.8	42.0	90.8	37.6	51.4	1.8
1977	149.1	46.4	102.7	43.0	57.8	2.0
1978	167.4	50.6	116.7	49.1	65.6	2.1
1979	189.6	55.8	133.8	56.9	74.6	2.3
1980	219.1	62.5	156.7	67.3	86.7	2.6
1981	253.4	70.8	182.6	78.8	100.8	3.0
1982	284.7	77.2	207.5	90.8	113.4	3.4
1983	313.3	85.2	228.1	100.0	124.5	3.7

NOTE: Details may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, Winter 1984.

Table 5.9
Personal Consumption Expenditures by Type of Product in the United States, 1983

Type of Product	Personal consumption expenditures (billions of dollars)	Percent of total
Food (including alcohol)	$ 416.4	19.3%
Housing	363.3	16.9
Household operation	294.8	13.7
Transportation	291.9	13.5
Medical care*	234.9	10.9
Clothing, accessories and jewelry	150.0	7.0
Recreation	141.3	6.6
Personal business	127.7	5.9
Private education and research	33.3	1.5
Religious and welfare activities	32.3	1.5
Tobacco	28.3	1.3
Personal care	27.8	1.3
Foreign travel and remittances-net	8.6	0.4
Death expenses	5.3	0.2
Total	$2,155.9	100.0%

*Includes all expenses for health insurance (except loss of income type).

SOURCES: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, July 1984, and Health Insurance Association of America.

Table 5.10
Ratio of Personal Consumption Expenditures for Medical Care to Disposable Personal Income and to Total Personal Consumption Expenditures in the United States

(000,000,000 omitted)

(1)	(2)	(3)	(4)	(5)	(6)
Calendar year	Personal consumption expenditures for medical care*	Disposable personal income	Total personal consumption expenditures	Ratio of col. (2) to col. (3)	Ratio of Col. (2) to col. (4)
1950	$ 8.8	$ 206.6	$ 192.0	4.3%	4.6%
1955	12.8	275.0	253.7	4.7	5.0
1960	19.5	352.0	324.9	5.5	6.0
1965	29.4	475.8	430.4	6.2	6.8
1966	31.8	513.7	465.1	6.2	6.8
1967	34.2	547.9	490.3	6.2	7.0
1968	37.9	593.4	536.9	6.4	7.1
1969	43.7	638.9	581.8	6.8	7.5
1970	49.3	695.3	621.7	7.1	7.9
1971	54.4	751.8	672.2	7.2	8.1
1972	60.6	810.3	737.1	7.5	8.2
1973	67.4	914.5	812.0	7.4	8.3
1974	75.5	998.3	888.1	7.6	8.5
1975	85.4	1,096.1	976.4	7.8	8.7
1976	96.2	1,194.4	1,084.3	8.1	8.9
1977	110.5	1,314.0	1,204.4	8.4	9.2
1978	123.0	1,474.0	1,346.5	8.3	9.1
1979	141.8	1,650.2	1,507.2	8.6	9.4
1980	166.8	1,828.9	1,668.1	9.1	10.0
1981	194.4	2,041.7	1,849.1	9.5	10.5
1982	218.6	2,180.5	1,984.9	10.0	11.0
1983	234.9	2,340.1	2,155.9	10.0	10.9

*Includes all expenses for health insurance (except loss of income type).

SOURCES: U.S. Department of Commerce, Bureau of Ecomomic Analysis, *Survey of Current Business* (various issues), and Health Insurance Association of America.

Table 5.11
Personal Consumption Expenditures for Medical Care in the United States (000,000,000 omitted)

Calendar year	Total medical care	Hospital services	Physicians' services	Medicines and appliances	Dentists' services	Net cost of health insurance	All other medical care
1950	$ 8.8	$ 2.0	$ 2.6	$ 2.2	$ 1.0	$0.3	$ 0.7
1955	12.8	3.2	3.5	3.0	1.5	0.6	1.0
1960	19.5	5.3	5.2	4.6	2.0	0.8	1.6
1965	29.4	8.4	8.0	6.2	2.8	1.3	2.8
1966	31.8	9.4	8.5	6.5	2.9	1.4	3.1
1967	34.2	10.7	9.4	6.7	3.2	1.4	2.8
1968	37.9	12.3	10.1	7.5	3.5	1.6	2.8
1969	43.7	15.1	11.5	8.4	4.1	1.9	2.7
1970	49.3	17.6	13.1	9.4	4.6	1.8	2.8
1971	54.4	20.5	14.4	9.9	4.9	2.1	2.6
1972	60.6	22.8	15.7	10.8	5.3	3.2	2.7
1973	67.4	25.4	17.5	11.7	6.3	3.5	3.1
1974	75.5	29.7	19.4	12.8	6.9	3.6	3.2
1975	85.4	34.7	22.5	13.9	7.9	2.8	3.6
1976	96.2	40.4	25.3	15.1	8.9	2.4	4.1
1977	110.5	46.3	29.5	16.4	10.0	3.3	5.1
1978	123.0	52.4	30.9	18.0	12.1	3.3	6.3
1979	141.8	60.1	36.6	20.1	12.9	4.5	7.7
1980	163.8	70.6	43.1	21.7	14.8	4.7	8.9
1981	191.4	83.0	48.9	23.8	17.0	6.3	12.4
1982	215.6	95.8	54.6	25.5	18.4	7.6	13.7
1983	234.9	104.1	61.2	28.0	19.5	8.3	13.8

NOTE: Data are revised. The data exclude private expenditures in federal, state, city and other government hospitals and nursing homes. In some cases the sum of the items does not equal the "Total medical care" shown because of rounding.

SOURCES: U.S. Department of Commerce, Bureau of Economic Analysis, *The National Income and Product Accounts of the United States, 1929-76 Statistical Tables* and July 1984 Special Supplement to *Survey of Current Business*.

Table 5.12
Consumer Price Index for Medical Care Items in the United States (Annual Average, 1967 = 100.0)

Calendar year	All medical care items	Physicians' fees	Dentists' fees	Hospital room	Drugs and prescriptions	
					Prescription drugs	Over the counter items
Urban wage and clerical workers						
1947	48.1	51.4	56.9	23.1	—	—
1950	53.7	55.2	63.9	30.3	92.6	—
1955	64.8	65.4	73.0	42.3	101.6	—
1960	79.1	77.0	82.1	57.3	115.3	—
1965	89.5	88.3	92.2	75.9	102.0	98.0
1966	93.4	93.4	95.2	83.5	101.8	99.0
1967	100.0	100.0	100.0	100.0	100.0	100.0
1968	106.1	105.6	105.5	113.6	98.3	102.5
1969	113.4	112.9	112.9	128.8	99.6	103.2
1970	120.6	121.4	119.4	145.4	101.2	106.2
1971	128.4	129.8	127.0	163.1	101.3	110.3
1972	132.5	133.8	132.3	173.9	100.9	111.3
1973	137.7	138.2	136.4	182.1	100.5	112.4
1974	150.5	150.9	146.8	201.5	102.9	117.5
1975	168.6	169.4	161.9	236.1	109.3	130.1
1976	184.7	188.5	172.2	268.6	115.2	138.9
1977	202.4	206.0	185.1	299.5	122.1	148.5
1978	219.4	223.3	199.3	331.6	132.1	159.1
All urban consumers						
1978	219.4	223.1	198.1	332.4	131.6	159.0
1979	239.7	243.6	214.8	370.3	141.8	170.7
1980	265.9	269.3	240.2	418.9	154.8	188.1
1981	294.5	299.0	263.3	481.1	172.5	211.4
1982	328.7	327.1	283.6	556.7	192.7	234.2
1983	357.3	352.3	302.7	619.6	213.8	251.7
1984	379.5	376.8	331.4	670.9	234.3	267.3

NOTE: Beginning January 1978, the Bureau of Labor Statistics introduced a new index for all urban consumers.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, *CPI Detailed Report*.

Table 5.13
Annual Changes in Consumer Price Index

Calendar year	All items	All medical care items	Physicians' fees	Dentists' fees	Hospital room	Drugs and prescriptions: Prescription drugs	Drugs and prescriptions: Over the counter items
Urban wage and clerical workers							
1947	14.4%	8.3%	6.4%	8.4%	17.3%	9.9%	—
1950	11.0	1.9	1.5	2.4	3.4	2.7	—
1955	–0.4	2.2	3.5	1.0	4.2	1.4	—
1960	1.6	3.5	2.5	2.0	6.9	–0.3	—
1965	1.7	2.5	3.6	3.1	5.6	–1.1	0.7%
1966	2.9	4.4	5.8	3.3	10.0	–0.2	1.0
1967	2.9	7.1	7.1	5.0	19.8	–1.8	1.0
1968	4.2	6.1	5.6	5.5	13.6	–1.7	2.5
1969	5.4	6.9	6.9	7.0	13.4	1.3	0.7
1970	5.9	6.3	7.5	5.8	12.9	1.6	2.9
1971	4.3	6.5	6.9	6.4	12.2	0.1	3.9
1972	3.3	3.2	3.1	4.2	6.6	–0.4	0.9
1973	6.2	3.9	3.3	3.1	4.7	–0.4	1.0
1974	11.0	9.3	9.2	7.6	10.7	2.4	4.5
1975	9.1	12.0	12.3	10.3	17.2	6.2	10.7
1976	5.8	9.5	11.3	6.4	13.8	5.4	6.8
1977	6.5	9.6	9.3	7.5	11.5	6.0	6.9
1978	7.6	8.4	8.4	7.7	10.7	8.2	7.1
All urban consumers							
1979	11.3	9.3	9.2	8.4	11.4	7.8	7.4
1980	13.5	10.9	10.6	11.8	13.1	9.2	10.2
1981	10.4	10.8	11.0	9.6	14.8	11.4	12.4
1982	6.1	11.6	9.4	7.7	15.7	11.7	10.8
1983	3.2	8.7	7.7	6.7	11.3	10.9	7.5
1984	4.3	6.2	7.0	8.1	8.3	9.6	6.2

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, *CPI Detailed Report*.

Table 5.14
Consumer Price Index in the United States
(Annual Average, 1967 = 100.0)

Calendar year	All items	Food	Apparel	Housing	Transportation	Medical care	Entertainment	Other goods and services
Urban wage and clerical workers								
1935	41.1	36.5	40.8	49.3	42.6	36.1	41.8	44.6
1940	42.0	35.2	42.8	52.4	42.7	36.8	46.1	48.3
1945	53.9	50.7	61.5	59.1	47.8	42.1	62.4	56.9
1950	72.1	74.5	79.0	72.8	68.2	53.7	74.4	60.9
1955	80.2	81.6	84.1	82.3	77.4	64.8	76.7	79.8
1960	88.7	88.0	89.6	90.2	89.6	79.1	87.3	87.8
1965	94.5	94.4	93.7	94.9	95.9	89.5	95.9	94.2
1966	97.2	99.1	96.1	97.2	97.2	93.4	97.5	97.2
1967	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
1968	104.2	103.6	105.4	104.2	103.2	106.1	104.7	104.6
1969	109.8	108.9	111.5	110.8	107.2	113.4	108.7	109.1
1970	116.3	114.9	116.1	118.9	112.7	120.6	113.4	116.0
1971	121.3	118.4	119.8	124.3	118.6	128.4	119.3	120.9
1972	125.3	123.5	122.3	129.2	119.9	132.5	122.8	125.5
1973	133.1	141.4	126.8	135.0	123.8	137.7	125.9	129.0
1974	147.7	161.7	136.2	150.6	137.7	150.5	133.8	137.2
1975	161.2	175.4	142.3	166.8	150.6	168.6	144.4	147.4
1976	170.5	180.8	147.6	177.2	165.5	184.7	151.2	153.3
1977	181.5	192.2	154.2	189.6	177.2	202.4	157.9	159.2
1978	195.3	206.2	159.5	202.6	185.8	219.4	176.2	183.2
All urban consumers								
1978	195.4	211.4	159.6	202.8	185.5	219.4	176.6	183.3
1979	217.4	234.5	166.6	227.6	212.0	239.7	188.5	196.7
1980	246.8	254.6	178.4	263.3	249.7	265.9	205.3	214.5
1981	272.4	274.6	186.9	293.5	280.0	294.5	221.4	235.7
1982	289.1	285.7	191.8	314.7	291.5	328.7	235.8	259.9
1983	298.4	291.7	196.5	323.1	298.4	357.3	246.0	288.3
1984	311.1	302.9	200.2	336.5	311.7	379.5	255.1	307.7

NOTE: Beginning January 1978, the Bureau of Labor Statistics introduced a new index for all urban consumers.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, *CPI Detailed Report*.

Table 5.15
Average Cost to Community Hospitals Per Patient Day and Per Patient Stay; Average Length of Stay in Community Hospitals in the United States

Calendar year	Average cost to hospital per patient day			Average length of hospital stay (days)	Average cost to hospital per patient stay
	Total	Payroll	Other		
1946	$ 9.39	$ 4.98	$ 4.41	9.1	$ 85.45
1950	15.62	8.86	6.76	8.1	126.52
1955	23.12	14.26	8.86	7.8	180.34
1960	32.23	20.08	12.15	7.6	244.95
1961	34.98	21.54	13.44	7.6	265.85
1962	36.83	22.79	14.04	7.6	279.91
1963	38.91	24.01	14.90	7.7	299.61
1964	41.58	25.26	16.32	7.7	320.17
1965	44.48	27.44	17.04	7.8	346.94
1966	48.15	29.41	18.74	7.9	380.39
1967	54.08	32.44	21.64	8.3	448.86
1968	61.38	36.61	24.77	8.4	515.59
1969	70.03	41.36	28.67	8.3	581.25
1970	81.01	47.30	33.71	8.2	664.28
1971	92.31	53.80	38.51	8.0	738.48
1972	105.30	59.80	45.50	7.9	831.70
1973	102.40	57.00	45.40	7.8	798.70
1974	113.60	61.90	51.70	7.8	886.10
1975	133.80	70.90	62.90	7.7	1,030.30
1976	151.80	78.00	73.80	7.7	1,168.90
1977	174.00	87.40	86.60	7.6	1,322.40
1978	194.30	96.60	97.70	7.6	1,476.70
1979	217.30	107.30	110.00	7.6	1,651.50
1980	245.10	119.20	125.90	7.6	1,862.80
1981	284.30	138.20	146.10	7.6	2,160.70
1982	327.40	157.80	169.60	7.6	2,488.20
1983	369.49	176.25	193.24	7.6	2,789.18

NOTE: Data prior to 1972 include hospital units of institutions. Total expenses include: payroll expenses; employee benefits; professional fees; depreciation expense; supplies and purchased services. Payroll expenses include: physicians' and dentists' salaries; medical and dental interns and residents; trainees in medical technology and administration; other personnel. Data for years 1973-1983 have been adjusted to include outpatients.

SOURCES: American Hospital Association, *Hospital Statistics* (various annual editions), and Health Insurance Association of America.

Table 5.16
Community Hospital Statistics—1983

	Average cost to hospital per day	Average length of hospital stay	Average cost to hospital per stay
Alabama	$321.99	7.1	$2,275.55
Alaska	577.60	5.9	3,385.48
Arizona	466.93	6.8	3,155.05
Arkansas	287.07	6.6	1,898.47
California	565.22	6.4	3,634.79
Colorado	387.29	7.1	2,750.03
Connecticut	396.43	7.7	3,048.32
Delaware	354.83	7.9	2,809.75
District of Columbia	501.11	8.7	4,418.88
Florida	379.82	7.4	2,820.87
Georgia	317.34	6.7	2,132.78
Hawaii	357.87	8.2	2,963.59
Idaho	304.92	6.5	1,989.02
Illinois	413.08	7.9	3,238.88
Indiana	336.74	7.5	2,532.89
Iowa	310.44	7.7	2,404.36
Kansas	331.25	7.6	2,517.50
Kentucky	297.51	6.9	2,036.30
Louisiana	383.34	6.2	2,306.71
Maine	351.42	7.2	2,533.73
Maryland	358.11	8.2	2,917.07
Massachusetts	417.09	8.7	3,609.29
Michigan	399.43	8.0	3,169.27
Minnesota	298.65	9.2	2,743.44
Mississippi	250.11	7.0	1,755.78
Missouri	368.10	7.9	2,893.24
Montana	258.60	8.5	2,172.15
Nebraska	278.94	8.6	2,393.73
Nevada	558.50	6.2	3,488.44
New Hampshire	328.05	7.0	2,272.20
New Jersey	309.63	8.0	2,491.06
New Mexico	480.73	6.1	2,518.19
New York	346.89	9.6	3,335.31
North Carolina	286.76	7.5	2,157.93
North Dakota	270.16	8.6	2,319.56
Ohio	371.59	7.9	2,916.80
Oklahoma	358.06	6.6	2,351.07
Oregon	426.55	5.9	2,502.36
Pennsylvania	371.57	8.4	3,098.55
Rhode Island	370.80	8.1	3,001.55
South Carolina	291.13	7.3	2,138.62
South Dakota	244.24	8.6	2,098.47
Tennessee	299.76	7.3	2,184.67
Texas	353.83	6.6	2,318.82
Utah	432.42	5.4	2,317.32
Vermont	283.44	8.2	2,309.08
Virginia	320.13	7.8	2,496.08
Washington	422.94	5.7	2,421.93
West Virginia	302.71	7.1	2,149.34
Wisconsin	322.67	8.1	2,619.85
Wyoming	348.73	5.6	1,935.14
Total U.S.	$369.49	7.6	$2,789.18

SOURCE: American Hospital Association, *Hospital Statistics, 1984*.

Table 5.17
Comparison of Hospital Semiprivate Room Charges by State, July 1984 and January 1985, and Percent Change

State	Semiprivate Room Charge		Percent Change
	July 1984	Jan. 1985	July 1984-Jan. 1985
Alabama	$160.17	$162.22	1.3%
Alaska	254.98	273.98	7.5
Arizona	190.59	192.59	1.0
Arkansas	141.78	141.16	–0.4
California	276.82	281.20	1.6
Colorado	209.52	212.38	1.4
Connecticut	198.54	205.98	3.7
Delaware	213.49	214.16	0.3
District of Columbia	272.99	273.71	0.3
Florida	177.82	181.78	2.2
Georgia	148.28	150.72	1.6
Hawaii	227.53	230.82	1.4
Idaho	194.17	199.10	2.5
Illinois	243.80	246.60	1.1
Indiana	183.04	184.23	0.7
Iowa	175.25	179.47	2.4
Kansas	179.85	184.11	2.4
Kentucky	167.08	175.74	5.2
Louisiana	149.54	156.31	4.5
Maine	208.70	209.04	0.2
Maryland	182.02	187.33	2.9
Massachusetts	220.64	228.92	3.8
Michigan	264.42	269.86	2.1
Minnesota	184.37	188.21	2.1
Mississippi	111.30	113.56	2.0
Missouri	183.25	185.43	1.2
Montana	195.45	203.02	3.9
Nebraska	152.61	154.62	1.3
Nevada	238.96	241.32	1.0
New Hampshire	197.55	199.27	0.9
New Jersey	180.50	182.61	1.2
New Mexico	189.39	191.78	1.3
New York	225.71	223.63	–0.9
North Carolina	137.54	139.24	1.2
North Dakota	169.99	175.63	3.3
Ohio	228.00	228.94	0.4
Oklahoma	166.74	165.10	–0.1
Oregon	222.28	230.02	3.5
Pennsylvania	250.83	255.65	1.9
Rhode Island	200.70	205.10	2.2
South Carolina	129.03	140.04	8.5
South Dakota	158.63	161.85	2.0
Tennessee	138.62	142.26	2.6
Texas	154.64	158.57	2.5
Utah	167.27	169.09	1.1
Vermont	202.57	211.27	4.3
Virginia	162.10	164.12	1.2
Washington	220.19	228.96	4.0
West Virginia	160.31	163.81	2.2
Wisconsin	165.35	166.80	0.9
Wyoming	155.24	166.00	6.9
Total U.S.	$209.43	$212.77	1.6%

SOURCE: Health Insurance Association of America, *Survey of Hospital Semiprivate Room Charges*, January 1985.

Table 5.18
1984 Fees for Surgical, OBG, and Emergency Medical Procedures in the United States

Specialty	High Range	Percent Charging	Middle Range	Percent Charging	Low Range	Percent Charging
General Surgeons						
Appendectomy	$ 800-1,000†	17%	$ 500- 775	68%	$ 400*- 475	15%
Cholecystectomy	1,000-1,500†	39	750- 975	49	650*- 750	12
Inguinal hernia, unilateral	800-1,000†	19	500- 800	63	400*- 475	18
OBG Specialists						
Complete OB care	$1,000-1,400†	24%	$ 700- 975	58%	$ 400*- 675	18%
Total Hysterectomy	1,200-2,000†	42	900-1,175	43	700*- 875	15
D&C (Diagnostic)	400- 500†	26	250- 375	61	200*- 225	13
D&C (Therapeutic)	400- 500†	32	250- 375	58	200*- 225	10
Orthopedic Surgeons						
Ganglionectomy (Wrist)	$ 700-1,200†	6%	$ 300- 675	67%	$ 250*- 275	27%
Total Hip Arthroplasty	3,000-4,000†	33	2,000-2,975	52	1,500*-1,975	15
Closed Reduction (Colles' fracture)	400- 500†	24	200- 375	70	150*- 175	6
Otolaryngologists						
Adenoidectomy	$ 300- 500†	37%	$ 200- 295	44%	$ 150*- 195	19%
Tonsillectomy	400- 500†	42	250- 395	45	250*- 250	13
Laryngectomy	2,000-3,000†	42	1,050-1,950	53	1,000*-1,000	5
Neurosurgeons						
Cranioplasty	$2,000-3,500†	41%	$1,100-1,900	56%	$1,000*-1,000	11%
Craniotomy	3,000-4,500†	44	2,000-2,900	45	1,500*-1,900	11
Lumbar Laminectomy	2,000-3,500†	44	1,400-1,900	46	1,000*-1,300	10
Plastic Surgeons						
Facial Rhytidectomy	$3,000-4,000†	39%	$2,000-2,975	50%	$1,500*-1,975	11%
Breast augmentation, bilateral	2,000-3,000†	37	1,500-1,900	37	1,000*-1,400	26
Thoracic Surgeons						
Open Heart Surgery (with bypass)	$4,000-5,500†	52%	$3,000-3,900	35%	$2,500*-2,900	13%
Lobectomy	2,000-3,000†	49	1,500-1,900	31	1,000*-1,400	20
Insertion of pacemaker	1,500-2,000†	28	1,000-1,400	51	600*- 900	21
Thoracentesis	200- 300†	18	100- 175	43	50*- 95	39
Emergency Medicine						
Critical care (first 60 minutes)	$ 150- 250†	25%	$ 75- 145	59%	$ 50*- 65	16%
Repair of superficial wound (2.5 to 7.5 cm)	70- 100†	23	40- 65	56	30*- 35	21
Cardiopulmonary resuscitation	175- 300†	38	75- 150	54	50*- 70	8

†or more

*less than

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Table 5.19
Average Dentist Charges, Selected Areas National and Regional of the United States, 1984

Procedure	U.S. Average	Far West	Mountain	Southwest	Southeast	Midwest	Mid Atlantic	New England
Exam/diagnosis	$ 15	$ 19	$ 14	$ 17	$ 12	$ 14	$ 17	$ 18
Full mouth x-ray	33	38	31	30	30	31	35	35
Adult prophylaxis	24	32	19	25	23	22	26	24
Amalgram, 2 surfaces	34	44	34	39	25	33	30	35
Full gold crown	331	340	301	337	272	307	371	390
Porcelain crown with gold	330	350	319	338	277	322	367	400
Fluoride treatment	21	28	19	22	19	19	22	23
Complete dentures	770	906	756	879	602	795	728	803

SOURCE: *Procom Fourth Annual Survey of Dental Fees and Incomes*. Supplement to Procom Update – Volume 11, No. 4, April 1984.

Table 5.20
Median Office-Visit Fees by Type of Physician, 1982, 1983 and 1984

	First office visit (usual)			Office revisit (usual)		
	1982	1983	1984	1982	1983	1984
General Practitioners	$21	$22	$25	$17	$19	$20
Family Practitioners	21	24	24	18	19	20
Internists	36	35	40	22	24	25
General Surgeons	26	26	26	20	20	20
OBGs	40	40	41	23	25	25
Pediatricians	25	26	30	20	21	22
All Nonsurgical Specialists	46	35	39	24	23	25
All Surgical Specialists	40	35	39	21	21	23

SOURCE: *Medical Economics Continuing Survey*. Copyright (c) 1984. Published by Medical Economics Company, at Oradell, N.J. 07649. Reprinted by permission.

Table 5.21
Regional Variations in Median Physician Fees, 1984

Region* and type of visit	General practitioners	Family practitioners	All surgical specialists	All nonsurgical specialists
East				
Initial visit	$25	$25	$42	$40
Revisit	20	21	26	26
South				
Initial visit	23	25	36	36
Revisit	20	20	24	24
Midwest				
Initial visit	21	21	35	33
Revisit	18	18	21	21
West				
Initial visit	31	27	46	45
Revisit	25	22	26	29

*East includes New England and Mid-eastern states; South, South Atlantic, Mid-southern and Southwestern states; Midwest, Great Lakes and Plains states; and West, Rocky Mountain and Far Western states.

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Table 5.22
Total Medical Costs of Having a Baby, 1982

Region	Usual Delivery		Cesarean
	Delivery Room	Birthing Room	
Northeast			
Urban	$2,312.50	$2,199.20	$3,708.60
Rural	2,127.10	N.A.	3,328.50
Total	2,285.50	N.A.	3,647.50
South			
Urban	1,960.20	1,930.20	3,044.40
Rural	1,810.10	1,782.70	2,916.50
Total	1,912.30	1,889.60	2,986.30
North Central			
Urban	2,287.00	2,137.10	3,620.40
Rural	1,833.80	1,726.80	3,064.90
Total	2,128.40	2,003.80	3,427.20
West			
Urban	2,283.50	2,321.40	3,762.20
Rural	1,615.80	1,503.30	2,860.10
Total	2,148.50	2,170.50	3,584.80
U.S.			
Urban	2,209.10	2,175.90	3,511.80
Rural	1,819.70	1,734.90	3,001.70
Total	2,092.70	2,062.50	3,340.30

N.A.—Not available.

NOTE: Excludes anesthesiologist's professional fee, which averages $150 nationally for a usual delivery, and pediatrician's newborn care, which averages $64 nationally.

SOURCE: Health Insurance Association of America, Public Relations Division, *The Cost of Having a Baby*.

Table 5.23
Certain Costs of Accidents by Class, 1983 (000,000,000 omitted)

Cost	Total*	Motor vehicle	Work	Home	Public nonmotor vehicle
Total	$92.7	$43.3	$33.4	$10.0	$7.6
Wage loss	24.3	12.6	5.4	3.5	4.1
Medical expense	12.7	3.8	3.8	3.0	2.4
Insurance administration	16.6	10.0	6.4	0.1	0.1
Fire loss	6.6	†	2.2	3.4	1.0
Motor vehicle property damage	16.9	16.9	†	†	†
Indirect work loss	15.6	†	15.6	†	†

*Duplications between work and motor vehicle and home and motor vehicle are eliminated in the totals.

†Not included.

SOURCE: *Accident Facts*, 1984 edition, Copyright (c) 1984 by National Safety Council, Reprinted by permission.

Chapter 6
Disability and Health Care Utilization

Disability

Disability rates for both acute and chronic health conditions—as measured by work-loss days, restricted activity days and disability days—vary by social and economic characteristics.

Table 6.1 shows that the higher the educational attainment, the fewer days of disability. Marked differences in the number of disability days are also found in relation to income. The differentials in disability by occupation are not as marked—blue-collar workers averaged 5.2 work-loss days while white-collar workers averaged 4.3 work-loss days in 1982.

The disability rates also vary by geographic region. Among the four regions (Northeast, North Central, South and West), persons in the West had the highest level of restricted activity days, 15.6, and the highest frequency of physician visits, 5.8 per person per year. (For definitions, see Table 6.2.) Persons in the South registered the highest rate of bed-disability, 7.4 per person per year.

Acute Conditions. Some 271 million workdays were lost in 1982 as a result of some acute health condition. (For definition, see footnote, Table 6.3.) This was an average of 2.7 days off the job for each worker in the nation.

A rate of 3.7 school-loss days per child between the ages of 5 and 17 was reported for 1982 (Table 6.4).

Chronic Conditions. Chronic illness invariably has a long-term impact on people, changing their lifestyles to the extent that they can no longer carry on their major activity, such as working or keeping house, or limiting the kind or duration of their activities. In 1982, 32 million persons, 14.3% of the U.S. civilian noninstitutional population, suffered a limitation of activity because of one or more chronic conditions (Table 6.5). Of that number, some 23 million or 9.9%, suffered limitation of their major activity.

Occupational Injuries and Illness. According to the U.S. Department of Labor's latest survey, approximately 4.7 million work-related injuries occurred in 1983, about the same as in 1982 (Table 6.6).

Some 36.4 million workdays were lost because of work-related injuries in 1983 — up from 36.1 million in 1982. The rate per 100 full-time workers decreased from 57.5 lost workdays a year in 1982 to 57.2 in 1983.

About 106,000 reported cases of occupational illnesses were recorded in 1983 compared with 105,600 in 1982.

Social Security Disability Insurance Program. The Social Security Disability Insurance program is the largest federal income program for disabled persons. Table 6.7 shows the growth of the Disability Insurance program from 1965 to 1984. The number of recipients (both the number of workers, and the number of workers and dependents) was greatest in 1978, and had decreased each year since, but rose again in 1984.

Trends in Utilization Of Services

Hospital Utilization. Approximately one of six Americans (based on the civilian noninstitutional population) was admitted to a community hospital in 1983. Community hospitals, defined as nonfederal, short-term, general and special hospitals providing general medical care to the public, account for 81% of all hospitals and handle 90% of all admissions.

An average of 99,046 persons entered community hospitals each day in 1983—36,151,780 admissions over the 12-month period. This was a 14.1% increase over 1973.

On an average day in 1983, there were 749,000 patients in community hospitals, or 3.2 per 1,000 population.

The nation's community hospitals treated 210 million outpatient cases in 1983. This was a 21.4% increase over 1973.

A National Center for Health Statistics survey of short-stay hospital utilization in 1982 reported the average length of stay was 7.5 days for males and 6.8 days for females. Females, however, had a higher rate of hospitalization than males, 179.2 per 1,000 compared to 120.1 per 1,000 for men. Length of stay increased with age from 4.6 days for children under 15, to 10.1 days for persons aged 65 and over. The Northeast registered the longest average length of stay, 8.2 days for all ages, while the Western region had the shortest, 5.9 days.

Physician Visits. According to estimates of the U.S. Department of Health and Human Services' *National Health Interview Survey,* Americans made 1,173 million visits to physicians in 1982. The average number of visits per person was 5.2. (For definition, see Table 6.12.)

A government survey of ambulatory patient visits in 1981 (where there was contact with a physician) showed that the largest proportion of office visits, 33%, were made to general and family practitioners. About 37% of visits were due to acute conditions, 37% to chronic conditions and 26% were post-surgery, post-injury or non-illness related. Visits to solo practitioners outnumbered those to physicians in multiple-member practices 55% to 45%.

Office visits per year increased in direct proportion to advancing age. About 63% of all office visits by adults were made by women.

Diseases of the respiratory system accounted for 12.5% of all visits and another 10% of visits were for diseases of the circulatory system.

The following eight diagnostic groups accounted for 77% of the principal diagnoses made by physicians in office practice.

	Percent
Special conditions and examinations without illness	17.2
Diseases of the respiratory system	12.5
Diseases of the circulatory system	10.0
Diseases of the nervous system and sense organs	9.7
Injuries and poisonings	8.3
Diseases of the genitourinary system	6.1
Diseases of the musculoskeletal system and connective tissue	7.2
Diseases of the skin and subcutaneous tissue	5.7

Table 6.1
Disability Due to Chronic and Acute Conditions, by Social and Economic Characteristics in the United States, 1982

(Days per person)

Characteristics	Restricted activity	Bed disability	Work-loss
Sex			
Both Sexes	14.3	6.4	4.6
Males	12.5	5.4	4.0
Female	16.0	7.3	5.3
Family Income			
Under $5,000	28.4	12.8	5.8
$ 5,000 - 9,999	22.4	10.3	5.6
10,000 - 14,990	16.0	7.3	5.2
15,000 - 19,000	12.8	5.4	4.6
20,000 - 24,000	11.6	4.9	4.8
25,000 - 34,999	10.2	4.1	4.4
35,000 and over	9.3	3.9	3.9
Educational Attainment			
Under 9 Years	30.0	13.6	5.6
9 - 11 Years	20.2	9.4	6.2
12 Years	13.9	5.9	4.7
13 - 15 Years	13.3	5.7	4.5
16 Years and Over	10.5	4.2	3.2
Occupation			
White Collar	9.4	3.5	4.3
Professional, Technical & Kindred	8.9	3.2	3.7
Managers & Administrators (except farm)	8.2	3.0	3.6
Clerical & Kindred	10.8	4.0	5.5
Sales	9.4	3.6	4.0
Blue Collar	9.9	3.8	5.2
Craftsmen & Kindred	9.4	3.2	4.5
Operatives & Kindred	10.5	4.4	5.9
Laborers (except farm)	9.2	3.6	5.4
Service	10.8	4.2	4.7
Farm	7.4	2.3	3.4

NOTE: The data refer to the civilian, noninstitutional population. A "Restricted activity day" is one on which a person cuts down on his usual activities for the whole of that day because of an illness or injury. A "Bed disability day" is one on which a person stays in bed for all or most of the day because of a specific illness or injury. A "Work-loss day" is a day on which a currently employed person, 18 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. "Family Income" includes the total income of each member of the family. "Educational Attainment" refers to the number of years of schooling the individual has received.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *National Health Interview Survey*, unpublished data.

Table 6.2
Selected Health Characteristics by Geographic Region in the United States, 1982 (Days/visits per person)

Characteristics	Total	Geographic Region			
		Northeast	North Central	South	West
Restricted activity days*	14.3	13.5	12.8	15.4	15.6
Days of bed disability*	6.4	6.1	5.3	7.4	6.5
Work-loss days*	4.6	4.7	4.5	4.7	4.5
Physician visits	5.2	5.2	5.0	4.9	5.8

*Chronic and acute conditions.

NOTE: The data refer to the civilian, noninstitutional population. A "Restricted activity day" is one on which a person cuts down on his usual activities for the whole of that day because of an illness or injury. A "Bed disability day" is one on which a person stays in bed for all or most of the day because of a specific illness or injury. A "Work-loss day" is a day on which a currently employed person, 18 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. A "Physician visit" is a consultation with a physician, in person or by telephone, for examination, diagnosis, treatment or advice. A "Dental visit" is any visit to a dentist's office for treatment or advice.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, unpublished data.

Table 6.3
Workdays Lost Due to Acute Conditions in the United States, 1982

Acute Conditions	Number of work-loss days (000,000)			Work-loss days per employed person		
	All ages 18 and over	Age 18-44	Age 45 and over	All ages 18 and over	Ages 18-44	Age 45 and over
Both Sexes						
All acute conditions	271	190	80	2.7	2.8	2.6
Infective and parasitic diseases	25	19	6	0.3	0.3	0.2
Respiratory conditions	103	74	29	1.0	1.1	0.9
Digestive system conditions	13	9	4	0.1	0.1	0.1
Injuries	78	52	27	0.8	0.8	0.9
All other acute conditions	52	37	15	0.5	0.5	0.5
Male						
All acute conditions	130	91	40	2.3	2.4	2.2
Infective and parasitic diseases	10	7	3	0.2	0.2	0.2
Respiratory conditions	49	34	14	0.9	0.9	0.8
Digestive system conditions	7	5	2	0.1	0.1	0.1
Injuries	46	34	13	0.8	0.9	0.7
All other acute conditions	19	11	8	0.3	0.3	0.4
Female						
All acute conditions	140	100	41	3.3	3.3	3.2
Infective and parasitic diseases	15	12	3	0.3	0.4	0.2
Respiratory conditions	54	40	14	1.3	1.3	1.1
Digestive system conditions	6	4	2	0.1	0.1	0.2
Injuries	32	18	14	0.8	0.6	1.1
All other acute conditions	33	26	8	0.8	0.9	0.6

NOTE: The data refer to the civilian, noninstitutional population. An acute condition is one which lasted less than 3 months and which involved either medical attention or restricted activity. A "Work-loss day" is a day on which a currently employed person, 18 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. In some cases the sum of the items does not equal the total shown, because of rounding.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *National Health Interview Survey*, unpublished data.

Table 6.4
Days Lost from School Per 100 Children (5-17 years) Per Year, Due to Acute Conditions, by Sex and Condition Group: United States, 1982

Condition Group	Both sexes	Male	Female
All acute conditions	365.7	352.6	379.4
Infective and parasitic diseases	65.1	67.3	62.8
Respiratory conditions	205.9	195.3	217.0
Upper respiratory conditions	97.9	89.9	106.2
Influenza	91.6	92.4	90.8
Other respiratory conditions	16.5	13.1*	20.0
Digestive system conditions	15.4	12.3*	18.7
Injuries	37.4	37.8	37.1
All other acute conditions	41.8	39.9	43.8

NOTE: Details may not add to totals due to rounding.

*Figures do not meet standards of reliability or precision.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *National Health Interview Survey*, unpublished data.

Table 6.5
Percent Distribution of Persons with Limitation of Activity Due to Chronic Conditions, by Degree of Limitation According to Sex and Age: 1982 (Civilian noninstitutional population)

Sex and age	Percent distribution			
	Total population	With activity limitation	With limitation in major activity	With no activity limitation
Both sexes				
All ages	100.0%	14.3%	9.9%	85.7%
Under 17 years	100.0	4.8	3.5	95.2
17 - 44 years	100.0	8.3	5.4	91.7
45 - 64 years	100.0	25.0	18.9	75.0
65 years and over	100.0	40.7	27.0	59.3
Male				
All ages	100.0	13.9	10.2	86.1
Under 17 years	100.0	5.6	4.2	94.4
17 - 44 years	100.0	8.9	6.1	91.1
45 - 64 years	100.0	24.2	19.8	75.8
65 years and over	100.0	40.1	26.7	59.9
Female				
All ages	100.0	14.6	9.7	85.4
Under 17 years	100.0	3.9	2.7	96.1
17 - 44 years	100.0	7.7	4.7	92.3
45 - 64 years	100.0	25.6	18.0	74.4
65 years and over	100.0	41.2	27.2	58.8

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *National Health Interview Survey*, unpublished data.

Table 6.6
Number of Occupational Injuries and Illnesses, and Lost Workdays, Private Sector, by Industry Division, in the United States, 1983

Industry	Total cases* (000)	Lost workday cases (000)	Total lost workdays (000)	Average lost workdays per lost workday case
Injuries and illness				
Private sector†	4,854	2,183	37,201	17
Agriculture, forestry and fishing†	88	45	669	15
Mining	79	42	1,179	20
Construction	495	210	3,945	19
Manufacturing	1,773	764	12,983	17
Transportation and public utilities	379	218	4,395	20
Wholesale and retail trade	1,186	506	7,874	16
Wholesale trade	346	160	2,496	16
Retail trade	786	346	5,377	16
Finance, insurance and real estate	95	42	623	15
Services	759	356	5,534	16
Injuries				
Private sector†	4,748	2,140	36,374	17
Agriculture, forestry and fishing†	85	44	659	15
Mining	78	42	1,170	28
Construction	489	208	3,913	19
Manufacturing	1,713	739	12,440	17
Transportation and public utilities	374	216	4,370	20
Wholesale and retail trade	1,177	503	7,806	16
Wholesale trade	343	159	2,473	16
Retail trade	835	344	5,334	16
Finance, insurance and real estate	94	41	604	15
Services	739	349	5,411	16
Illnesses				
Private sector†	106	42	828	20
Agriculture, forestry and fishing†	4	1	9.6	9
Mining	1	.5	9	1.8
Construction	5	2	32	16
Manufacturing	60	25	543	22
Transportation and public utilities	5	2	26	13
Wholesale and retail trade	9	4	67	17
Wholesale trade	4	2	23	12
Retail trade	6	2	43	22
Finance, insurance and real estate	2	.8	19	24
Services	21	7	123	18

*Includes fatalities. †Excludes farms with fewer than 11 employees.

NOTE: Because of rounding, the sum of the components may not add to the totals. Differences between the estimate of total cases and the estimates for lost workday cases and nonfatal cases without lost workdays may not reflect the fatality estimate.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics.

Table 6.7
Growth in the Social Security Disability Insurance Program, 1965-84

Year	Number of workers insured for disability (000,000 omitted)	Disabled workers receiving benefits		Total disability insurance beneficiaries (000 omitted)	Total cash benefits paid for disability (000,000,000 omitted)
		Number (000 omitted)	Number per 100,000 insured workers		
1965	53.3	988.1	1,854	1,739.1	$ 1.6
1966	55.0	1,097.2	1,995	1,970.3	1.8
1967	55.7	1,193.1	2,142	2,140.2	1.9
1968	56.9	1,295.3	2,276	2,335.1	2.3
1969	70.1	1,394.3	1,989	2,487.5	2.5
1970	72.4	1,492.9	2,062	2,665.0	3.1
1971	74.5	1,647.7	2,212	2,930.0	3.8
1972	76.1	1,832.9	2,409	3,271.5	4.5
1973	77.8	2,016.6	2,592	3,559.0	5.7
1974	80.4	2,236.9	2,782	3,911.3	6.9
1975	83.3	2,488.8	2,988	4,352.2	8.4
1976	85.3	2,670.2	3,130	4,623.8	10.0
1977	87.0	2,837.4	3,261	4,860.4	11.5
1978	89.4	2,879.8	3,221	4,868.5	12.5
1979	93.8	2,870.4	3,060	4,777.4	13.7
1980	98.0	2,861.3	2,993	4,682.2	15.4
1981	100.4	2,776.5	2,868*	4,456.3	17.2*
1982	102.5*	2,603.7	N.A.	3,973.5	17.3
1983	103.7*	2,568.9	N.A.	3,812.9	17.5
1984	106.6*	2,596.5	N.A.	N.A.	N.A.

*Preliminary estimate.

NOTE: Number of disabled workers in current payment status as of December 31 of the year indicated. Insured workers as of January 1 of the year indicated.

SOURCES: U.S. Department of Health and Human Services, Social Security Administration, *Social Security Bulletin*, Annual Supplement 1983; U.S. Senate, Committee on Finance, *Staff Data and Materials Related to the Social Security Disability Insurance Program, 1983*; and unpublished data.

Table 6.8
Utilization of Community Hospitals in the United States
(Per 1,000 Population)

Year	Beds	Average daily census	Admissions
1950	3.4	2.5	111.4
1955	3.5	2.5	117.3
1960	3.6	2.7	129.2
1965	3.9	3.0	138.8
1970	4.2	3.3	145.6
1971	4.3	3.3	148.2
1972	4.3	3.2	150.0
1973	4.3	3.3	153.2
1974	4.4	3.4	157.8
1975	4.5	3.4	159.2
1976	4.5	3.4	160.5
1977	4.6	3.4	161.4
1978	4.6	3.4	161.1
1979	4.6	3.4	162.4
1980	4.5	3.4	165.8
1981	4.5	3.4	161.9
1982	4.4	3.3	156.7
1983	4.3	3.2	154.4

NOTE: Data refer to the civilian noninstitutional population.

SOURCES: American Hospital Association, *Hospital Statistics* (various annual editions), and Health Insurance Association of America.

Table 6.9
Rate of Discharges and Average Length of Stay for Patients Discharged from Short-Stay Non-Federal Hospitals, by Sex: United States, 1983

All Listed Diagnostic Categories*	Rate of discharges per 1,000 population*			Average length of stay (days)		
	Total	Male	Female	Total	Male	Female
All conditions	167.0	138.8	193.2	6.9	7.4	6.6
All Ischemic Heart Disease	9.0	11.0	7.1	8.5	8.2	9.0
Malignant Neoplasms and Carcinoma-In-Situ	8.7	8.9	8.6	10.7	10.7	10.6
Benign Neoplasms and Neoplasms of uncertain behavior	2.7	1.3	4.0	6.2	6.6	6.1
Fractures, all sites	4.7	4.8	4.6	10.2	8.9	11.5
Diseases of the Urinary System	5.2	5.3	5.1	6.6	6.6	6.5
Pneumonia, all forms	3.6	3.8	3.4	8.0	7.8	8.3
Chronic Disease of Tonsils and Adenoids	1.7	1.6	1.8	1.8	1.8	1.9
Cerebrovascular Disease	3.7	3.6	3.8	11.7	11.3	12.2
Diabetes Mellitus	2.9	2.3	3.5	9.5	9.3	9.6
Inguinal Hernia	2.1	3.8	0.4	4.1	4.0	4.6
Choleithiasis	2.1	1.3	2.8	8.7	9.4	8.3
Appendicitis	1.1	1.3	1.0	5.4	4.9	5.9
Childbirth	--	—	72.1†	—	—	3.6
With complications	—	—	40.4†	—	—	4.2
Without complications	—	—	31.7†	—	—	2.8

*Based on number of "all listed" diagnoses, to include all incidences of condition. This results in higher rates of discharge than data for previous years.

†Rate of discharge for childbirth is based on population of women aged 15-44.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, unpublished data.

Table 6.10
Rate of All Listed Surgical Operations for Patients Discharged from Short-Stay Non-Federal Hospitals, by Age and Sex: United States, 1983

Age	Rate per 1,000 population		
	Both sexes	Male	Female
Total	112.9	82.6	141.1
Under 15 years	34.6	40.2	28.7
15-44 years	115.4	53.4	175.7
45-64 years	127.7	120.2	134.5
65 years and over	226.1	254.5	207.1

NOTE: Rates are based on surgical operations exciuding biopsies and diagnostic procedures.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, unpublished data.

Table 6.11
Selected Community Hospital Facilities, Services and Special Beds in the United States, 1983

Selected facility or service	Percent of community hospitals
Emergency department	85.1%
Postoperative recovery room	98.0
Rehabilitation outpatient	33.8
Family planning services	12.0
Open-heart surgery facilities	10.5
X-ray therapy	16.0
Megavoltage therapy	14.7
Radioactive implants	20.6
Organ transplant	3.8
Blood bank	66.2
Respiratory therapy	84.2
Premature nursery	24.7
Speech pathology services	41.0
Hemodialysis (inpatient)	22.8
Genetic counseling services	7.2
Physical therapy	85.3
Occupational therapy	43.3
Psychiatric partial hospitalization program	13.6
Psychiatric outpatient services	19.8
Alcoholism/chemical dependency outpatient services	16.9
Home care department	14.5
Hospice	8.6

SOURCE: American Hospital Association, *Hospital Statistics, 1984*.

Table 6.12
Number of Physician Visits Per Person in the United States, 1982

	All ages	Under 18 years	18-24 years	25-44 years	45-64 years	65 years and over
Both Sexes	5.2	4.2	4.4	4.8	6.1	7.7
Male	4.5	4.2	3.0	3.7	5.7	7.2
Female	5.8	4.1	5.7	5.9	6.5	8.1

NOTE: The data refer to the civilian, noninstitutional population. A "Physician Visit" is a consultation with a physician, in person or by telephone, for examination, diagnosis, treatment or advice.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *National Health Interview Survey*, unpublished data.

Chapter 7
Health Manpower

According to the Department of Labor, some 6.1 million persons were active in the health field in 1984.

Physicians

According to the U.S. Department of Health & Human Services latest available figures, there were 483,700 active physicians in the United States and possessions at year-end 1983. Some 88% of all active non-federal physicians were involved in direct care of their patients while the remainder were engaged in administration, research, teaching and other activities. Of those in patient care, 73% had office-based practices and 27% had hospital-based practices. Some 14% of physicians were women.

According to Table 7.3, in 1982 the District of Columbia had the highest ratio of non-federal physicians to population, followed by Massachusetts, Maryland, New York and Connecticut. The lowest ratios of physicians to population occurred in Idaho, Mississippi, Wyoming and South Dakota.

Dentists

In 1982, the number of active dentists in the United States reached an estimated 126,800. According to the latest available data (Table 7.3), the District of Columbia, Massachusetts, Connecticut, New York and Oregon had the highest ratios of dentists to population, while Mississippi, Arkansas, Alabama and South Carolina had the lowest. Table 7.1 shows that 63% of the dental work force in 1982 was comprised of auxiliary personnel (dental hygienists and assistants).

Nurses

Between 1965 and 1983, the number of registered nurses employed in nursing more than doubled to reach 1,404,200. The data, while excluding inactive nurses, include those employed in nursing on a part-time basis.

In 1983, there were 781,506 licensed practical nurses employed in nursing. Licensed practical nurses provide personal care to patients, including most of the personal care given to elderly patients in long-term care institutions (Table 7.1).

Pharmacists

In 1982, there were 149,630 licensed pharmacists in the United States. In 1982 21.4% of pharmacists were women.

About 72% of active pharmacists practiced privately in community pharmacies, and 20% practiced full- or part-time in hospitals. Other pharmacists were employed by manufacturers, taught or were engaged in other pharmaceutical activities such as research.

Table 7.1
Estimated Number of Persons Active in Selected Health Occupations, 1982

Occupation	Number of persons active
Clinical Laboratory Technician and Technologist	209,000
Dentistry and allied services	
Dentist	132,000*
Dental hygienist	69,000
Dental assistant	153,000
Dietician	44,000
Nursing and related services	
Registered nurse	1,404,200†
Practical nurse	781,506
Nursing aide, orderly, attendant	1,218,000
Pharmacist	149,630
Physician (includes Doctor of Medicine and Doctor of Osteopathy)	483,700*
Psychologist	83,000
Radiologic Technologist	110,000
Therapist (includes occupational, physical, respiratory, speech)	202,000

*1982 Estimates.

†1983 Estimates.

SOURCE: Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services, 1984.

Table 7.2
Estimated Active Health Professionals in the United States
(50 States and District of Columbia)

	Total Number			Per 100,000 Population*		
Year	Physicians	Dentists	Nurses	Physicians	Dentists	Nurses
1965	288,700	96,000	613,000	146	49	317
1970	326,500	102,200	722,000	156	50	356
1971	322,228	N.A.	750,000	156	N.A.	366
1972	333,259	105,500	780,000	160	51	376
1973	338,111	N.A.	815,000	161	N.A.	390
1974	350,609	N.A.	857,000	166	N.A.	407
1975	366,425	112,000	906,000	174	52	427
1976	399,500	115,000	961,000	179	53	449
1977	405,900	117,900	1,055,400	180	53	408
1978	424,000	129,600	1,123,200†	187	54	506
1979	440,400	123,500	1,199,700†	192	55	534
1980	457,500	126,200	1,272,900†	197	55	560
1981	466,600	129,180	1,315,500†	199	56	574
1982	483,700	132,000	1,357,300	205	57	586
1983	N.A.	N.A.	1,404,200	N.A.	N.A.	600

N.A —Not available.

*Resident population of 50 states and District of Columbia.

†Preliminary estimate.

NOTE: Data are revised from previous editions and include federally-employed professionals in the 50 states and the District of Columbia. "Physicians" refers to all active physicians. "Dentists" refers to all active dentists. "Nurses" refers to registered nurses employed in nursing.

SOURCE: Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services, 1984.

Table 7.3
Number and Rate per 100,000 Population of Active Physicians, Pharmacists and Dentists, by State, 1982

State	Non-Federal Physicians		Dentists		Pharmacists*	
	Number	Rate**	Number	Rate†	Number	Rate†
Alabama	5,061	129	1,468	37	2,956	75
Alaska	516	123	246	61	173	41
Arizona	5,016	175	1,292	45	1,902	66
Arkansas	2,889	126	840	36	1,777	77
California	55,600	228	15,097	62	10,769	43
Colorado	5,739	190	1,882	63	1,940	64
Connecticut	7,850	252	2,341	74	2,300	73
Delaware	1,020	171	272	46	279	46
District of Columbia	3,163	512	565	92	709	114
Florida	18,252	176	4,735	45	5,237	49
Georgia	8,056	144	2,318	41	3,961	70
Hawaii	1,902	202	616	65	316	32
Idaho	1,052	108	511	53	600	62
Illinois	21,571	189	6,420	56	7,579	66
Indiana	7,131	130	2,462	45	4,104	75
Iowa	3,770	130	1,563	54	2,365	82
Kansas	3,700	156	1,154	49	1,460	61
Kentucky	5,046	138	1,718	47	2,542	69
Louisiana	6,795	156	1,750	40	2,499	56
Maine	1,708	152	537	47	714	63
Maryland	11,482	272	2,669	62	2,765	64
Massachusetts	15,317	276	4,198	77	4,665	80
Michigan	14,810	163	5,318	58	7,049	77
Minnesota	7,933	192	2,709	66	3,003	73
Mississippi	2,794	110	824	33	2,068	81
Missouri	8,181	166	2,545	51	3,770	76
Montana	1,306	130	492	62	628	79
Nebraska	2,341	148	1,026	65	1,368	86
Nevada	1,238	143	381	43	405	45
New Hampshire	1,560	165	512	54	563	59
New Jersey	14,582	197	4,955	67	4,428	59
New Mexico	2,057	152	612	45	779	57
New York	47,280	270	12,875	73	10,711	61
North Carolina	9,182	155	2,375	40	2,647	60
North Dakota	919	139	326	50	547	82
Ohio	18,024	168	5,574	52	6,351	59
Oklahoma	4,052	127	1,313	42	2,393	75
Oregon	4,753	178	1,871	70	1,885	71
Pennsylvania	23,060	194	6,803	57	8,394	71
Rhode Island	1,962	207	515	54	815	85
South Carolina	4,234	134	1,218	39	2,387	74
South Dakota	812	118	326	50	542	80
Tennessee	7,391	160	2,344	51	3,558	77
Texas	22,811	150	6,288	41	9,785	64
Utah	2,511	160	993	63	1,152	73
Vermont	1,120	215	312	60	258	50
Virginia	9,489	178	2,731	51	3,239	59
Washington	7,525	178	2,839	67	2,896	67
West Virginia	2,712	138	805	41	1,195	61
Wisconsin	7,702	163	3,020	63	3,832	80
Wyoming	582	115	244	48	370	72
Total United States	425,795	185	126,810	55	148,630	65
U.S. territories and possessions including Puerto Rico	4,114	113	N.A.	N.A.	N.A.	N.A.
Grand Total	429,909	N.A.	126,810	55	148,630	65

N.A.—Not available.

*Data concerning pharmacists were collected during 1982.

**Rates based on civilian population as of 7/1/81.

†Rates based on resident population as of 7/1/81.

NOTE: "Physicians" and "Dentists" refer to all active non-federal physicians and dentists. "Pharmacists" refers to all licensed non-federal pharmacists.

SOURCES: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Associated and Dental Health Professions.

Appendix I

Historic Dates

1798 U.S. Marine Hospital Service established by U.S. Congress. Compulsory deductions for hospital service were made from seamen's wages.

1847 The first insurer to issue sickness insurance was organized: The Massachusetts Health Insurance Company of Boston.

1849 New York State passed the first general insurance law.

1850s The first insurance supervisory boards were created in New Hampshire, Massachusetts, Rhode Island and Vermont.

1850 Individual accident insurance became available in the United States with the chartering of the Franklin Health Assurance Company in Massachusetts.

1851 One of the earliest voluntary mutual protection associations, *La Societe Francaise de Bienfaisance Mutuelle*, was organized in San Francisco. It is noteworthy for having established a hospital in 1852 to provide care for its members.

1855 The first separate insurance department, independent of any established agency, was created in Massachusetts.

1859 The first full-time insurance commissioner was appointed in New York.

1863 The Travelers Insurance Company of Hartford, Connecticut, offered accident insurance for railway mishaps; then all forms of accident protection. It was the first company to issue insurance on a basis resembling its present form.

1875 A number of mutual benefit associations, called "establishment funds," were formed for employees of a single employer. The benefits provided usually included small payments for death and disability.

1890 Policies providing benefits for disability from specified diseases were first offered.

1890s This period brought the promotion of many fraternal associations, assessment mutuals and industrial insurers. Because many of these companies and associations were inadequately financed and poorly managed, many states passed legislation against them.

1900 Shortly after the turn of the century, disability benefits became available for substantially all diseases.

1910 Montgomery Ward & Co., Inc. replaced its "employee establishment fund" with an insured contract. This plan is generally regarded as the first group health insurance policy.

1912 The Standard Provisions Law drafted by the National Convention of Insurance Commissioners (now the NAIC) was enacted by most states. This model law sought to provide uniformity and fairness in the

"operating conditions" of the health insurance contract.

1916 First non-cancellable disability income contract was offered.

1917 Group accidental death and dismemberment insurance was first written.

1920s Early in this decade individual hospitals began offering hospital expense benefits on an individual prepaid basis.

1920s First partial disability benefits for sickness and accident became available.

1929 The first health maintenance organization, the Ross-Loos Clinic, was established in Los Angeles, California.

1929 A group of school teachers arranged for Baylor Hospital in Dallas, Texas to provide room and board and specified ancillary services at a predetermined monthly cost. This plan is considered the forerunner of what later became known as the Blue Cross plans.

1929 With the depression, many companies entered a period of retrenchment in their disability income product line, particularly in the area of maintaining reasonable indemnity limits in order to avoid overinsurance.

1930s The depression stimulated the expansion of insurance coverages through both public demand and hospitals' encouragement.

1932 First citywide Blue Cross plan was tried out with a group of hospitals in Sacramento, California.

1935 The Social Security Act (P.L. 74-241) provided for the first time grant-in-aid to states for such public health activities as maternal and child care, aid to crippled children, blind persons, the aged and other health-impaired persons.

1937 Health Service Plan Commission (Blue Cross Commission) was organized.

1938 Hospital insurance for dependents of covered persons was developed.

1938 Private insurers introduced group surgical expense benefit plans.

1939 The first Blue Shield plan (surgical-medical), called the California Physicians' Service, was developed.

1940s During World War II, as a result of the freezing of wages, group health insurance became an important component of collective bargaining for employee benefits.

1942 Compulsory cash sickness benefits were begun by four states (Rhode Island, 1942; California, 1946; New Jersey, 1948; New York, 1949).

1943 Private insurers introduced group medical expense benefits (physician's visits expense benefits).

1946 The Health Insurance Council, a federation of eight insurance associations organized to give technical and practical assistance on health insurance to the providers of medical care, was formed.

1946 Blue Shield Medical Care Plans, Inc. (Blue Shield Commission) was organized.

1948 The National Labor Relations

Board ruled, in a dispute between the United Steel-workers' Union and the Inland Steel Company, that the term "wages" be construed to include pension and insurance benefits. The U.S. Supreme Court upheld this ruling in a 1949 decision.

1949 Major medical expense benefits were introduced by Liberty Mutual Insurance Company to supplement basic medical care expenses.

1954 Congress introduced the disability "freeze" that stated that the quarters during which a worker is disabled are not counted in determining the number of quarters needed to be fully or currently insured under Old Age and Survivors Insurance (OASI).

1956 Disability insurance was added to the Social Security System, providing monthly cash benefits for insured persons who are totally disabled.

1957 Vision care expense benefits were introduced by private insurers, followed in 1959 by extended care facility expense benefits.

1959 Continental Casualty Company issued the first comprehensive group dental insurance plan written by an insurance company.

1960s First disability contracts for business use appeared (overhead expense, keyman).

1960s Eligibility for disability benefits under Social Security was expanded.

1961 First state enrollment plan was made available by Connecticut to persons 65 and over on a state basis and under special enabling legislation allowing the pooling of risks by a group of insurance companies (Associated Connecticut Health Insurance Companies).

1963 The Health Professions Educational Assistance Act (P.L. 88-129) aided training of physicians, dentists and other public health personnel.

1964 Prescription drug expense benefits were introduced.

1964 The Nurse Training Act (P.L. 88-581) provided special Federal effort for training professional nursing personnel.

1965 Social Security Amendments of 1965 (P.L. 89-97) established a Social Security hospital insurance program for the aged and voluntary supplementary medical insurance program (Medicare) and grants to states for medical assistance programs (Medicaid).

1966 Program of governmental health insurance, Medicare, for people aged 65 and over, became effective July 1.

1967 The Age Discrimination in Employment Act (ADEA) became effective.

- The Act applied only to employees between the ages of 40 and 65, and the vast majority of employee benefit plans provided them with the same benefits as younger employees.
- The Act contained a specific provision (Section 4(f)(2)) which stated that it was per-

missible for an employer to observe the terms of any bona fide employee benefit plan such as a retirement, pension or insurance plan which was not a subterfuge to evade the purposes of the Act.

1971 The Insurance Medical Scientist Scholarship Fund was formed by several insurance companies, providing full scholarships for students planning careers in medical research and teaching.

1972 Social Security Amendments of 1972 (P.L. 92-603) extended health insurance benefits (Medicare) to the disabled and to end-stage renal disease patients; established Professional Standards Review Organization (PSRO) programs; expanded research and demonstrations of financing mechanisms; and introduced automatic cost of living adjustments to disability benefits.

1972 Legislation created the Supplemental Security Income program, which federalized categorical public assistance for the aged, blind, and permanently and totally disabled.

1973 The Health Maintenance Organization Act (P.L. 93-222) assisted in the establishment and expansion of HMOs.

1974 Employee Retirement Income Security Act (ERISA) of 1974 signed into law. While generally thought of as a law that regulates private pension plans, the Act also contains provisions relating to other employee benefit plans that have encouraged the growth of self-insurance.

1975 The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) authorized major federal reorganization of health planning programs and set up the national designation of local Health Systems Areas and governing agencies.

1976 The Health Professions Educational Assistance Act of 1976 (P.L. 94-484) contained provisions requiring medical school students who receive federal scholarship aid to serve a specified period in rural and inner city areas, and required that medical schools with teaching hospitals provide for a greater proportion of medical residencies in primary medicine.

1976 The Health Maintenance Organization Amendments of 1976 (P.L. 94-460) relaxed requirements for HMOs to qualify for federal support.

1976 The National Consumer Health Information and Health Promotion Act of 1976 (P.L. 94-317) set forth national goals for health information and promotion and a systematic strategy for their achievement, stressing health education.

1977 The Medicare-Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142) amended the Social Security Act to require uniform reporting of financial data by providers; upgraded criminal penalties for fraud under Medicare-Medicaid programs; and amended certain Professional Standards Review Organization (PSRO) provisions.

1978 The Health Maintenance Organization Amendments of 1978 (P.L. 95-559) set forth a three-year extension of the HMO assistance program.

1978 Title VII of the Civil Rights Act of 1964 was amended to prohibit sex discrimination on the basis of pregnancy for all employment-related purposes.

1978 ADEA of 1967 was amended to raise the mandatory retirement age from 65 to 70. The Act prohibits discrimination concerning benefits to older workers. An employer may coordinate benefits with other programs—e.g., Medicare for employees over age 65—provided that total benefits are equivalent to those offered younger workers.

1981 The Omnibus Budget Reconciliation Act mandated significant cuts in federal expenditures for health programs; increased Medicare deductibles; removed limit on number of states that can apply for Medicare and Medicaid cost reimbursement waivers; and directed the Secretary of HHS to develop a model prospective reimbursement methodology for inpatient services under Medicare and Medicaid.

1982 Tax Equity and Fiscal Responsibility Act of 1982 provided Medicare recognition for any state hospital cost control system that meets certain federal standards, including equitable treatment of all payors; for employees age 65-69 with employer-sponsored health insurance, made Medicare secondary payor; brought federal employees under Medicare; and made certain changes in the methods of hospital reimbursements under Medicare.

1983 In response to the requirement of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, a prospective payment system for hospital care of medicare enrollees was enacted as a component of the Social Security Amendments of 1983.

1984 Omnibus Deficit Reduction Act of 1984 (P.L. 98-369) extended Medicare as secondary payer of aged spouses of workers under 65; froze Medicare reimbursement for physician fees; and reduced increases in hospital costs.

1984 National Organ Transplant Act of 1984 (P.L. 98-507) established a task force on organ transplantation; authorized grants for organ procurement organizations; and established bone marrow registry demonstration and study.

Appendix II

Adjustments for Duplication in Number of Persons under Age 65 Covered, 1983 (000 omitted)

Type of insurer	Number of People under Age 65 Covered				
	Hospital expense	Surgical expense	Physician's expense	Major medical expense	Dental expense*
Insurance Companies					
Group insurance (regular business)	64,492	62,087	60,224	75,235	48,932
ASO & MPP business	40,522	41,580	40,333	44,145	37,968
Total group insurance	105,014	103,667	100,557	119,380	86,900
Individual hospital medical expense coverage	11,908	10,797	10,257	6,796	—
Hospital indemnity	5,957	—	—	—	—
Total individual insurance	17,865	10,797	10,257	6,796	—
Deduction for duplication of persons with insurance company protection	19,591	15,183	14,652	15,511	9,559
Net Total for insurance companies	103,288	99,281	96,162	110,665	77,341†
Blue Cross/Blue Shield†	70,800	58,200	55,300	44,600	10,400
Other Plans†	51,400	56,900	55,100	45,400	52,600
Consumers (prepaid)†	15,400	19,900	19,900	15,900	21,000
Labor management (self-funded)†	36,000	37,000	35,200	29,500	31,600
Deduction for duplication of persons protected by more than one type of insurer	49,061	46,687	44,500	39,133	31,715
Net Total all insurers	176,427	167,694	162,062	161,532	108,626

†Estimate.

*All ages.

SOURCE: Health Insurance Association of America.

Appendix III

Adjustments for Duplication in Number of Persons Age 65 and Over Covered, 1983 (000 omitted)

Type of insurer	Number of People Age 65 and Over Covered			
	Hospital expense	Surgical expense	Physician's expense	Major medical expense
Insurance Companies				
Group insurance (regular business)	1,973	677	677	N.A.
ASO & MPP business	1,313	572	572	N.A.
Total group insurance	3,286	1,249	1,249	N.A.
Individual hospital medical expense coverage	4,810	2,768	2,768	N.A.
Hospital indemnity	1,799	—	—	—
Total individual insurance	6,609	2,768	2,768	N.A.
Deduction for duplication of persons with insurance company protection	2,344	967	967	N.A.
Net Total for insurance companies	7,551	3,050	3,050	N.A.
Blue Cross/Blue Shield†	8,800	7,900	7,500	N.A.
Other Plans†	6,300	4,900	4,800	N.A.
Consumers (Prepaid)†	1,900	1,700	1,700	N.A.
Labor management (self-funded)†	4,400	3,200	3,100	N.A.
Deduction for duplication of persons protected by more than one type of insurer	6,862	4,487	4,362	N.A.
Net Total all insurers	15,789	11,363	10,988	N.A.

N.A.—Not available.

†Estimate.

SOURCE: Health Insurance Association of America.

Glossary

Accident an event or occurrence which is unforeseen and unintended.

Accidental Bodily Injury injury to the body as the result of an accident.

Accumulation Period a specified period of time, such as 90 days, during which the insured person must incur eligible medical expenses at least equal to the deductible amount in order to establish a benefit period under a major medical expense or comprehensive medical expense policy.

Actuary a person professionally trained to apply probability and statistics to the practical problems of insurance and related fields. He/she may specialize in life insurance, health insurance (long-term disability and medical), property and casualty insurance, pension work, government programs or a combination of these. His/her responsibilities include calculation of premiums, policy values, reserves and dividends, preparation of statistical studies and forecasting of financial results. Because of his/her broad training an actuary often has administrative and executive responsibilities.

Administrative Services Only (ASO) Plan an arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group.

Adverse Selection the tendency of persons with poorer than average health expectations to apply for, or continue, insurance to a greater extent than do persons with average or better health expectations.

Age Limits stipulated minimum and maximum ages below and above which the company will not accept applications or may not renew policies.

Agent an insurance company representative licensed by the state who solicits, negotiates, or effects contracts of insurance, and provides service to the policyholder for the insurer.

Aggregate Indemnity the maximum dollar amount that may be collected for any disability, period of disability, or under the policy.

Allocated Benefits benefits for which the maximum amount payable for specific services is itemized in the contract.

Amendment a formal document changing the provisions of an insurance policy signed jointly by the insurance company officer and the policyholder or his authorized representative.

Application a signed statement of facts requested by the company on the basis of which the company decides whether or not to issue a policy. This then becomes part of the health insurance contract when the policy is issued.

Approval (1) word used in connection with the filing of policy and certificate forms and rates with the state insurance department. (2) a word used in connection with the underwriting process of an insurance company and consists of the acceptance of the risk as set forth in the application as made or modified by the insurer. (3) acceptance of an offer from an applicant or policyholder in the form of a contract for new insurance, reinstatement of a terminated policy, request for a policy loan, etc., by an officer of the company.

Assignment the signed transfer of benefits of a policy by the owner of the policy to a third party.

Association Group a group formed from members of a trade or a professional association for group insurance under one master health insurance contract.

Beneficiary the person designated or provided for by the policy terms to receive the proceeds upon the death of the insured.

Benefits the amount payable by the insurance company to a claimant, assignee, or beneficiary under each coverage.

Binding Receipt a receipt given for a premium payment accompanying the application for insurance. If the policy is approved, this binds the company to make the policy effective from the date of the receipt.

Blanket Contract a contract of health insurance affording benefits, such as accidental death and dismemberment, for all of a class of persons not individually identified. It is used for such groups as athletic teams, campers, travel policy for employees, etc.

Blanket Medical Expense a provision which entitles the insured person to collect up to a maximum established in the policy for all hospital and medical expenses incurred, without any limitations on individual types of medical expenses.

Blue Cross an independent, nonprofit membership corporation providing protection on a service basis against the cost of hospital care in a limited geographical area.

Blue Shield an independent, nonprofit membership corporation providing protection on a service basis against the cost of surgical and medical care in a limited geographical area.

Broker a sales and service representative who handles insurance for clients, generally selling insurance of various kinds and for several companies.

Business Insurance a policy which primarily provides coverage of benefits to a business as contrasted to an individual. It is issued to indemnify a business for the loss of services of a key employee or a partner who becomes disabled.

Certificate of Insurance a statement of coverage issued to an individual insured under a group insurance contract, outlining the insurance benefits and principal provisions applicable to the member.

Claim a demand to the insurer for the payment of benefits under the insurance contract.

Coinsurance a policy provision frequently found in major medical insurance, by which both the insured person and the insurer share the covered losses under a policy in a specified ratio, i.e., 80% by the insurer and 20% by the insured.

Comprehensive Major Medical Insurance a policy designed to give the protection offered by both a basic and a major medical health insurance policy. It is characterized by a low deductible amount, a coinsurance feature and high maximum benefits.

Consideration one of the elements for a binding contract. Consideration is acceptance by the insurance company of the payment of the premium and the statement made by the prospective policyholder in the application.

Contributory a group insurance plan issued to an employer under which both the employer and employee contribute to the cost of the plan. Seventy-five percent of the eligible employees must be insured. (see Noncontributory)

Conversion Privilege a privilege granted in an insurance policy to convert to a different plan of insurance without providing evidence of insurability. The privilege granted by a group policy is to convert to an individual policy upon termination of group coverage.

Coordination of Benefits (COB) the specific term used to designate the anti-duplication provision designed by the group health insurance industry through the Health Insurance Association of America (HIAA) to limit benefits for multiple group health insurance in a particular case to 100% of the expenses covered and to designate the order in which the multiple carriers are to pay benefits.

Covered Expenses hospital, medical, and miscellaneous health care expenses incurred by the insured that entitle him to a payment of benefits under a health insurance policy. Found most often in connection with major medical plans, the term defines, by either description, reasonableness, or necessity to specify the type and amount of expense which will be considered in the calculation of benefits.

Deductible the amount of covered charges incurred by the protected person which must be assumed or paid by the insured before benefits by the insurance company become payable. A deductible is most commonly used in major medical policies; however, it may also be incorporated in base plan policies.

Diagnosis-related groupings (DRGs) system that reimburses health care providers fixed amounts for all care given in connection with standard diagnostic categories.

Disability physical or mental handicap resulting from sickness or injury. It may be partial or total. (see Partial Disability; Total Disability)

Disability Income Insurance a form of health insurance that provides periodic payments to replace income when an insured person is unable to work as a result of illness, injury or disease.

Dismemberment loss of body members (limbs), or use thereof, or loss of sight due to injury.

Double Indemnity a policy provision usually associated with death, which doubles payment of a designated benefit when certain kinds of accidents occur.

Dread Disease Insurance insurance providing an unallocated benefit, subject to a maximum amount, for expenses incurred in connection with the treatment of specified diseases, such as cancer, poliomyelitis, encephalitis and spinal meningitis.

Duplication of Benefits overlapping or identical coverage of the same insured under two or more health plans, usually the result of contracts of different insurance companies, service organizations, or pre-payment plans; also known as multiple coverage.

Earned Premium that portion of a policy's premium payment for which the protection of the policy has already been given. For example, an insurance company is considered to have earned 75% of an annual premium after a period of nine months of an annual term has elapsed.

Effective Date the date on which the insurance under a policy begins.

Eligibility Date the date on which an individual member of a specified group becomes eligible to apply for insurance under the [group life or health] insurance plan.

Eligibility Period a specified length of time, frequently 31 days, following the eligibility date during which an individual member of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence of insurability.

Eligible Employees those members of a group who have met the eligibility requirements under a group life or health insurance plan.

Elimination Period a period of time between the period of disability and the start of disability income insurance benefits, during which no benefits are payable. (see Waiting Period)

Enrollment Card a document signed by an employee as notice of his/her desire to participate in the benefits of a group insurance plan.

Evidence of Insurability any statement of proof of a person's physical condition and/or other factual information affecting his/her acceptance for insurance.

Exclusions specific conditions or circumstances listed in the policy for which the policy will not provide benefit payments.

Experience a term used to describe the relationship, usually expressed as a percent or ratio, of premium to claims for a plan, coverage, or benefits for a stated time period.

Experience Rating the process of determining the premium rate for a group risk, wholly or partially on the basis of that group's experience.

Experience Refund a provision in most group policies for the return of premium to the policyholder because of lower than anticipated claims.

Family Expense Policy a policy which insures both the policyholder and his/her immediate dependents (usually spouse and children).

Flat Schedule a type of schedule in group insurance under which everyone is insured for the same benefits regardless of salary, position, or other circumstances.

Franchise Insurance a form of insurance in which individual policies are issued to the employees of a common employer or the members of an association under an arrangement by which the employer or association agrees to collect the premiums and remit them to the insurer.

Fraternal Insurance a cooperative type of insurance provided by social organizations for their members.

Geographic Divisions (in the United States)
NORTHEAST
New England: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic: New Jersey, New York, Pennsylvania
NORTH CENTRAL
East North Central: Illinois, Indiana, Michigan, Ohio, Wisconsin
West North Central: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
SOUTH
South Atlantic: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East South Central: Alabama, Kentucky, Mississippi, Tennessee
West South Central: Arkansas, Louisiana, Oklahoma, Texas
WEST
Mountain: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific: Alaska, California, Hawaii, Oregon, Washington.

Grace Period a specified period after a premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues.

Group Contract a contract of insurance made with an employer or other entity that covers a group of persons identified as individuals by reference to their relationship to the entity.

Guaranteed Renewable Contract a contract that the insured person or entity has the right to continue in force by the timely payment of premiums for a substantial period of time, during which period the insurer has no right to make unilaterally any change in any provision of the contract, while the contract is in force, other than a change in the premium rate for classes of policyholders.

Health Insurance protection which provides payment of benefits for covered sickness or injury. Included under this heading are various types of insurance such as accident insurance, disability income insurance, medical expense insurance, and accidental death and dismemberment insurance.

Health Maintenance Organization (HMO) an organization that provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment. The HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, and hospital-medical plans.

Hospice health care facility providing medical care and support services such as counseling to terminally ill persons.

Hospital Expense Insurance health insurance protection against the cost of hospital care resulting from the illness or injury of the insured person.

Hospital Indemnity a form of health insurance which provides a stipulated daily, weekly or monthly indemnity during hospital confinement. The indemnity is payable on an unallocated basis without regard to the actual expense of hospital confinement.

Hospital Medical Insurance a term used to indicate protection which provides benefits for the cost of any or all of the numerous health care services normally covered under various health care plans.

Incontestable Clause an optional clause which may be used in noncancellable or guaranteed renewable health insurance contracts providing that the insurer may not contest the validity of the contract after it has been in force for two (sometimes three) years.

Indemnity benefits paid in a predetermined amount in the event of a covered loss.

Individual Insurance policies which provide protection to the policyholder and/or his/her family. Sometimes called Personal Insurance as distinct from group and blanket insurance.

Injury Independent of All Other Means an injury resulting from an accident, provided that the accident was not caused by an illness.

Insurable Risk the conditions that make a risk insurable are: (a) the peril insured against must produce a definite loss not under the control of the insured, (b) there must be a large number of homogeneous exposures subject to the same perils, (c) the loss must be calcuiable and the cost of insuring it must be economically feasible, (d) the peril must be unlikely to affect all insureds simultaneously, (e) the loss produced by a risk must be definite and have a potential to be financially serious.

Insurance protection by written contract against the financial hazards (in whole or in part) of the happenings of specified fortuitous events.

Insurance Company any corporation primarily engaged in the business of furnishing insurance protection to the public.

Insuring Clause the clause which sets forth the type of loss being covered by the policy and the parties to the insurance contract.

Integration a coordination of the disability income insurance benefit with other disability income benefits, such as Social Security, through a specific formula to insure reasonable income replacement.

Key-Man or Key-Person Health Insurance an individual or group insurance policy designed to protect a firm against the loss of income resulting from disability of a key employee.

Lapse termination of a policy upon the policyholder's failure to pay the premium within the time required.

Legal Reserve the minimum reserve which a company must keep to meet future claims and obligations as they are calculated under the state insurance code.

Level Premium a premium which remains unchanged throughout the life of a policy.

Lifetime Disability Benefit a benefit to help replace income lost by an insured person as long as he/she is totally disabled, even for a lifetime.

Limited Policy a contract which covers only certain specified diseases or accidents.

Long-Term Disability Income Insurance insurance issued to an employer (group) or individual to provide a reasonable replacement of a portion of an employee's earned income lost through serious and prolonged illness or injury during the normal work career. (See also Integration)

Major Medical Insurance health insurance to finance the expense of major illness and injury. Characterized by large benefit maximums ranging up to $250,000 or no limit, the insurance, above an initial deductible, reimburses the major part of all charges for hospital, doctor, private nurses, medical appliances, prescribed out-of-hospital treatment, drugs and medicines. The insured person as co-insurer pays the remainder.

Manual Rate the premium rate developed for a group insurance coverage from the company's standard rate tables normally referred to as its rate manual or underwriting manual.

Medicaid state programs of public assistance to persons regardless of age whose income and resources are insufficient to pay for health care. Title XIX of the federal Social Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966.

Medicare the hospital insurance system and the supplementary medical insurance for the aged created by the 1965 amendments to the Social Security Act and operated under the provisions of the Act.

Minimum Group the least number of employees permitted under a state law to effect a group for insurance purposes; the purpose is to maintain some sort of proper division between individual policy insurance and the group forms.

Minimum Premium Plan an arrangement under which an insurance carrier will, for a fee, handle the administration of claims and insure against large claims for a self-insured group.

Miscellaneous Expenses expenses in connection with hospital insurance, hospital charges other than room and board, such as X-rays, drugs, laboratory fees and other ancillary charges. (Sometimes referred to as Ancillary Charges.)

Morbidity the incidence and severity of sicknesses and accidents in a well defined class or classes of persons.

Multiple Employer Trust (MET) a legal trust established by a plan sponsor that brings together a number of small, unrelated employers for the purpose of providing group medical coverage on an insured or self-funded basis.

National Association of Insurance Commissioners (NAIC) the association of insurance commissioners of various states formed to promote national uniformity in the regulation of insurance.

Noncancellable Guaranteed Renewable Policy an individual policy which the insured person has the right to continue in force until a specified age, such as to age 65, by the timely payment of premiums. During this period, the insurer has no right to unilaterally make any changes in any provision of the policy while it is in force.

Noncontributory a term applied to employee benefit plans under which the employer bears the full cost of the benefits for the employees. One hundred percent of the eligible employees must be insured.

Nondisabling Injury an injury which may require medical care, but does not result in loss of working time or income.

Nonoccupational Policy contract which insures a person against off-the-job accident or sickness. It does not cover disability resulting from injury or sickness covered by Worker's Compensation. Group Accident and Sickness policies are frequently nonoccupational.

Nonparticipating Insurance plan of insurance under which the policyholder is not entitled to share in the dividend distribution of the company.

Nonprofit Insurers persons organized under special state laws to provide hospital, medical or dental insurance on a nonprofit basis. The laws exempt them from certain types of taxes.

Occupational Hazards occupations which expose the insured to greater than normal physical dangers by the very nature of the work in which the insured is engaged, and the varying periods of absence from the occupation, due to the disability, that can be expected.

Optionally Renewable Contract a contract of health insurance in which the insurer reserves the right to terminate the coverage at any anniversary or, in some cases, at any premium due date, but does not have the right to terminate coverage between such dates.

Overhead Insurance a type of short-term disability income contract that reimburses the insured person for specified, fixed, monthly expenses, normal and customary in the operation and conduct of his/her business or office.

Partial Disability the result of an illness or injury which prevents an insured from performing one or more of the functions of his/her regular job.

Participating Insurance insurance issued by an insurance company providing participation in dividend distribution.

Physician's Expense Insurance coverage which provides benefits toward the cost of such services as doctor's fees for nonsurgical care in the hospital, at home or in a physician's office, and X-rays or laboratory tests performed outside the hospital. (Also called Regular Medical Expense Insurance.)

Policy the legal document issued by the company to the policyholder which outlines the conditions and terms of the insurance; also called the policy contract or the contract.

Policy Term that period for which an insurance policy provides coverage.

Pre-Existing Condition a physical and/or mental condition of an insured which first manifested itself prior to the issuance of his/her policy or which existed prior to issuance and for which treatment was received.

Preferred Provider Organization (PPO) an arrangement whereby a third party payor contracts with a group of medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients.

Premium the periodic payment required to keep a policy in force.

Pre-Paid Group Practice Plan a plan under which specified health services are rendered by participating physicians to an enrolled group of persons, with a fixed periodic payment in advance made by or on behalf of each person or family. If a health insurance carrier is involved, a contract to pay in advance for the full range of health services to which the insured is entitled under the terms of the health insurance contract. Such a plan is one form of Health Maintenance Organization (HMO).

Principal Sum the amount payable in one sum in the event of accidental death and in some cases accidental dismemberment.

Professional Standards Review Organization (PSRO) an organization in which practicing physicians assume responsibility for reviewing the propriety and quality of health care services provided under Medicare and Medicaid.

Proration the adjustment of benefits paid because of a mistake in the amount of the premiums paid or the existence of other insurance covering the same accident or disability.

Qualified Impairment Insurance a form of substandard or special class insurance which restricts benefits for the insured person's particular condition.

Reasonable and Customary Charge a charge for health care, which is consistent with the going rate or charge in a certain geographical area for identical or similar services.

Recurring Clause a provision in some health insurance policies which specifies a period of time during which the recurrence of a condition is considered a continuation of a prior period of disability or hospital confinement.

Rehabilitation (1) restoration of a totally disabled person to a meaningful occupation, (2) a provision in some long-term disability policies that provides for continuation of benefits or other financial assistance while a totally disabled insured is retraining or attempting to resume productive employment.

Reinstatement the resumption of coverage under a policy which has lapsed.

Reinsurance the acceptance by one or more insurers, called reinsurers, of a portion of the risk underwritten by another insurer who has contracted for the entire coverage.

Renewal continuance of coverage under a policy beyond its original term by the insurer's acceptance of the premium for a new policy term.

Residual Disability Benefits a provision in an insurance policy that provides benefits in proportion to a reduction of earnings as a result of disability, as opposed to the inability to work full-time.

Rider a document which amends the policy or certificate. It may increase or decrease benefits, waive the condition of coverage, or in any other way amend the original contract.

Risk any chance of loss.

Self-Administration the procedure where an employer maintains all records regarding the employees covered under a group insurance plan.

Self-Insurance a program for providing group insurance with benefits financed entirely through the internal means of the policyholder, in place of purchasing coverage from commercial carriers.

Senior Citizen Policies contracts insuring persons 65 years of age or over. In most cases these policies supplement the coverage afforded by the government under the Medicare program.

Short-Term Disability Income Insurance the provision to pay benefits to a covered disabled person as long as he/she remains disabled up to a specified period not exceeding two years.

Social Security Freeze a long-term disability policy provision which establishes that the offset from benefits paid by Social Security will not be changed regardless of subsequent changes in the Social Security law.

Special Risk Insurance coverage for risks or hazards of a special or unusual nature.

Standard Insurance insurance written on the basis of regular morbidity underwriting assumption used by an insurance company and issued at normal rates.

Standard Provision those contract provisions generally required by state statutes until superseded by the uniform policy provision.

Standard Risk a person who, according to a company's underwriting standards, is entitled to insurance protection without extra rating or special restrictions.

State Disability Plan a plan for accident and sickness, or disability insurance required by state legislation of those employers doing business in that particular state.

State Insurance Department a department of a state government whose duty is to regulate the business of insurance and give the public information on insurance.

Substandard Insurance insurance issued with an extra premium or special restriction to those persons who do not qualify for insurance at standard rates.

Substandard Risk an individual, who, because of health history or physical limitations, does not measure up to the qualification of a standard risk.

Surgical Expense Insurance health insurance policies which provide benefits towards the physician's or surgeon's operating fees. Benefits may consist of scheduled amounts for each surgical procedure.

Surgical Schedule a list of cash allowances attached to the policy, which are payable for various types of surgery, with a maximum amount based upon the severity of the operation.

Third Party Administration administration of a group insurance plan by some person or firm other than the insurer or the policyholder.

Time Limit the period of time during which a notice of claim or proof of loss must be filed.

Total Disability an illness or injury which prevents an insured person from continuously performing every duty pertaining to his/her occupation or engaging in any other type of work. (This wording varies among insurance companies.)

Travel Accident Policy a limited contract covering only accidents while an insured person is traveling, usually on a commercial carrier.

Unallocated Benefit a policy provision providing reimbursement up to a maximum amount for the cost of all extra miscellaneous hospital services, but not specifying how much will be paid for each type of service.

Underwriter the term as generally used applies to either (a) a company which receives the premiums and accepts responsibility for the fulfillment of the policy contract; (b) the company employee who decides whether or not the company should assume a particular risk; (c) the agent who sells the policy.

Underwriting the process by which an insurer determines whether or not and on what basis an application for insurance will be accepted.

Unearned Premium that portion of the paid premium applying to the unexpired portion of the policy term; or that portion of the paid premium for which protection has not been received.

Uninsurable Risk one not acceptable for insurance due to excessive risk.

Waiting Period the length of time an employee must wait from his/her date of employment or application for coverage, to the date his/her insurance is effective. (See Probationary Period.)

Waiver an agreement attached to a policy which exempts from coverage certain disabilities or injuries which are normally covered by the policy.

Waiver of Premium a provision included in some policies which exempts the policyholder from paying the premiums while an insured is totally disabled, during the life of the contract.

Worker's Compensation insurance against liability imposed on certain employers to pay benefits and furnish care to employees injured, and to pay benefits to dependents of employees killed in the course of or arising out of their employment.

Written Premiums the entire amount of premiums due in a year for all policies issued by an insurance company.

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